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INCARCERATION AND ALTERNATIVE SANCTIONS FOR DRUG OFFENDERS

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BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

THE MAJOR COMPONENTS OF THE CRIME AND DRUG PROBLEM IN AMERICA

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CONTENTS

STATEMENTS OF COMMITTEE MEMBERS

	Page
Biden, Hon. Joseph R., Jr.	1
Simon, Hon. Paul	5
Thurmond, Hon. Strom	110
Grassley, Hon. Charles E.	112

CHRONOLOGICAL LIST OF WITNESSES

Castle, Hon. Michael N., Governor, State of Delaware, and chairman, National Governors' Association Committee on Justice and Public Safety	6
Coughlin, Thomas A., III, commissioner, New York State Department of Corrections	18
James, Allen, ex-heroin and cocaine addict, and director of career development, Fortune Society, New York, NY; and Bruce Wald, director, Key Program, Gander Hill Prison, Wilmington, DE	41
Panel including: Dr. Addis Dolente, program manager, Substance Abuse Unit, Hillsborough County Sheriff's Office, Hillsborough, FL; and Lt. John Buchanan, program coordinator, Demand Reduction Program, Phoenix Police Department, Phoenix, AZ	81

ALPHABETICAL LIST AND SUBMITTED MATERIAL

Biden, Hon. Joseph R., Jr.:	
Letter from Dale Parent, senior analyst, Abt Associates Inc., also Chapter 3 of report entitled "Advice to Policy Makers"	30
Buchanan, Lt. John:	
Testimony	96
Prepared statement	98
Castle, Hon. Michael N.:	
Testimony	6
Coughlin, Thomas A., III:	
Testimony	18
Prepared statement	20
Dolente, Dr. Addis:	
Testimony	81
Prepared statement	85
Letters to Chairman Biden	91, 94
James, Allen:	
Testimony	41
Prepared statement	44
Wald, Bruce:	
Testimony	54
Prepared statement	56

INCARCERATION AND ALTERNATIVE SANCTIONS FOR DRUG OFFENDERS

TUESDAY, JULY 25, 1989

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The committee met, pursuant to notice, at 10:12 a.m., in room SD–226, Dirksen Senate Office Building, Hon. Joseph R. Biden, Jr., chairman of the committee, presiding.

Present: Senators Biden and Simon.

OPENING STATEMENT OF CHAIRMAN BIDEN

The CHAIRMAN. The hearing will come to order.

We are particularly pleased this morning to have a list of such distinguished witnesses, if I can be forgiven for being slightly parochial, the most distinguished of whom is our first witness, the Governor of the State of Delaware, Governor Castle.

Governor, you have been before enough of our committees to know the process, and if you will bear with us, I have an opening statement, and I know Senator Thurmond and others intend on being here. If they arrive before your testimony begins you will have to, as with mine, suffer through our brief opening statements.

We do have two very distinguished panels of witnesses who will be with us this morning.

First, I will say something that is not in my released statement. As I indicated some time ago, we are looking forward with genuine anticipation and interest to September 5. That is the day when the drug director William Bennett, will be presenting his national drug strategy as called for in the legislation creating the position that we put into effect last year. When he was confirmed, he had 180 days to come up with his proposal. The proposal is now due, and I am told that he is anxious, prepared and ready, to put forward his proposal on behalf of the administration, on behalf of the President in particular, on the 5th.

In the process, this committee has decided that it will continue not only the hearing schedule it had in place for dealing with the drug issue, but there are six basic principles which I believe any proposal should be judged against. We will be holding hearings the remainder of the two weeks we are in session and through the month of August on each of these specific principles that I believe are important and my colleagues believe are important that the national drug strategy be measured against.

Today the committee begins that series of hearings by examining one of the major components of the crime and drug problem in America. These hearings, like hearings held earlier this year, are being conducted in preparation for the release of the drug director's first national drug strategy which, as I will say for the third time and maybe even a fourth time, will come up on September the 5th.

Today's hearings will examine what is probably the most visible impact of the drug epidemic on our crime-fighting efforts—the crisis in the criminal justice system in this country—and it is a crisis.

One merely needs to look at the daily papers to see how bad the problem is. Drug offenders, arrested but then released, commit countless crimes while awaiting trial. And these crimes are not only repeat drug offenses, but a number of other offenses connected with drugs. They then are again convicted and sometimes then released. They flow through the criminal justice system untreated and unpunished, and we read about their subsequent crimes every, single day.

I'd like you to take a look at the chart we have here. It shows, if we took a total number of 100 felonies committed, only 38 of those felonies per 100 committed in the United States—only 38—are even reported. I would argue that in large part is because of the loss of faith and confidence the American people have in the criminal justice system. Of the 38 reported, six people end up being arrested, and of the six that end up being arrested, three end up being convicted; and of the three convicted, two end up in prison or in jail. The bad news is that out of every 100 felonies, only 2 people go to jail. The better news is that one out of three people arrested ends up being convicted and going to jail.

The point is the system has to work better than it does now.

Despite these troubling statistics, the State and Federal criminal justice systems are barely able to handle the small handful of felons who do go to prison. We still, as a consequence of those two people—two out of 100 going to jail, have an incredible overcrowding problem throughout our prison system. Almost 40 States out of the 50 States are under some type of court order to reduce overcrowding or to improve conditions in the prisons—40 out of 50; 80 percent.

The Federal prison system is currently operating and it is better off than most of the States' at 49 percent over capacity.

It should come as no surprise that the public is losing confidence in the Government's ability to meet one of its most fundamental responsibilities, and that is enforcing our basic criminal laws.

Responding to the drug crisis in the criminal justice system must be the first order of business for the new drug director, and as he develops his goals for a national strategy, I respectfully suggest that the goal for the criminal justice system should be both simple and ambitious. That is, ensuring that drug users and traffickers are held accountable for their crimes—a simple statement; a difficult task. This will require more than simple-minded calls for more prisons. Of course, it is true that additional prison space is desperately needed to deal with the violent and repeat drug offenders, and violent and repeat offenders who are not drug offenders. That

is why I am considering legislation that would establish ten regional prisons to house Federal as well as State prisoners with serious drug problems. This would be for State prisoners as well as Federal prisoners.

But we must also find alternatives to lengthy prison or jail terms for first-time offenders and for drug users. Drug users should be forced to answer for their actions. Nonviolent drug offenders should face, at the very least, stiff fines, punitive drug testing, mandatory drug treatment, and those who can afford it should be forced to pay for their own treatment. Other offenders, particularly youthful ones, should be sentenced to military-style boot camps if that is the most appropriate punishment for them.

Fortunately, with money that we have provided in recent anti-crime and anti-drug bills, many of these approaches are being tested at the State and local level—with promising results, I might add.

I look forward to the testimony of Governor Castle, who not only will be able to discuss some of the successful programs in Delaware, but also outline some of the innovative programs being tested by governors throughout the country.

I might add, in addition to my parochial pride in the Governor being here, he represents the National Governors' Conference on this subject; he is the chairman of their subcommittee dealing with crime and public safety.

In my own State of Delaware, officials are increasingly turning to non-prison alternatives for first-time and nonviolent drug offenders, including home detention through electronic monitoring, closely-supervised drug treatment and intensive community-based work release programs.

In an effort to break the cycle of crime and drug abuse by repeat offenders, the Gander Hill prison, one of our prisons in Delaware, has implemented a drug treatment program that is based on a proven model. This program separates some inmates who are drug offenders from the general prison population and provides tightly-structured treatment and work routines, backed up by stiff sanctions for prisoners who continue using drugs. And it might sound strange to you to say "continue using drugs"—drug use in prisons throughout the Nation is a serious problem which I will speak to in a moment.

Separating these prisoners is essential. Drugs and drug use are rampant in our prisons. For example, the Federal Bureau of Prisons has provided us with some examples of how common items like a shoe—a woman goes to visit her boyfriend or her husband in the prison system, wearing an ordinary, low-heeled shoe. Once in the prison system—and many prisons do not have the glass separating the prisoner, or have slots through which things can be passed even where that occurs—she leans down and takes off her shoe, and looks like a honeycomb underneath the shoe pad. Within there can be any kind of drug—in this case, there is a little green pill in there. Or, they can wear an insert like this, and taped underneath it is a straw filled with cocaine. Or, in many cases, many of the drug offenders' wives and girlfriends have children, and they bring the children into the prison because there is no other alternative for them, and they have baby food, and within a jar of Gerber car-

rots, they would have a substance tied in a little, tiny orange bag that could be filled with anything from crack to any other substance that in fact the particular abuser was accustomed to using.

In addition to that, there is a whole table up here filled with similar means through which you have drugs getting into our prison system.

I might add there is another way: pure, outright, unadulterated bribery; prison officials, guards, who in fact are "on the take" and are not honest.

Other States like New York and Virginia, and the Gander Hill program in Delaware, address this problem by separating inmates and providing intensive drug treatment and monitoring. In other States like New York, Georgia and Virginia, to name three, officials have established boot camps for young, nonviolent drug offenders, and as virtually any graduate of these programs can attest, sentencing someone to a boot camp is not being soft on crime and drugs.

Starting at 5:30 a.m., boot camp inmates face a demanding regime of strict discipline, military drills, physical exercise and hard labor, along with vocational training and drug treatment.

And in Phoenix, Arizona, the chief of police and the district attorney have established a "Do Drugs, Do Time" program. Drug users who are arrested are automatically charged with a felony and spend at least some time in jail. However, first-time offenders are offered a choice: either do time in jail or do it in a drug treatment program. Users who elect treatment must pay for the treatment. And if they successfully complete the treatment program, the felony charges are dropped—this is for first-time offenders.

But make no mistake—these new sanctions—drug testing, mandatory treatment, military-style boot camps—are no substitute for swift and sure punishment for major drug traffickers and violent offenders. And I will continue to fight for more money to beef up our police, prosecutors, criminal courts and prisons so that there can in fact be a place to put those who are the major traffickers when in fact they are apprehended and convicted.

But in our efforts to get tough on violent criminals and drug traffickers, we must not overlook the need to deal with the overwhelming number of nonviolent offenders and drug users who now face virtually no penalties whatsoever. For them, we need sanctions that are tough enough to provide real punishment, but do not rely solely on building expensive new prisons.

The innovative programs that we will discuss today, along with dozens of promising new programs across the country, do not provide easy answers for solving the crime and drug problem in America. That will take time. They cost money. And they cannot guarantee that a young drug offender will be cured of drug abuse or become a model citizen.

But they do offer some of the most promising sanctions available for achieving what must be one of the most basic goals of our national drug control strategy: ensuring that drug traffickers and users are held accountable for their crimes.

As I indicated, in conclusion, we will hold a series of six additional hearings on other aspects of the drug problem that in fact we will be judging the new drug strategy against. The first of those,

today, is to deal with the criminal justice system in this country and how it in fact deals with drug offenders.

I yield to my colleague from Illinois.

OPENING STATEMENT OF SENATOR SIMON

Senator SIMON. Thank you very, very much, Mr. Chairman.

Governor, you have to listen to us lobby you before you get a chance to lobby us here.

Two weeks ago yesterday, I spent the day in Chicago, where I started off with the U.S. Attorney and his drug task force; went with a couple of Chicago patrolmen on their beat, working on drug problems; visited with some addicts in a treatment center; met with some parents—just spent a day getting a feel for the problem. In the west side of Chicago, in the Austin area, I met with some people who were worried about drug sales in their neighborhood; we went out there, and they said you can see them selling it just two blocks from where we are. I went there, and literally—I guess it was drugs—you could see people working at it. One of the men told me they worked in shifts, and I laughed, thinking he was joking, and he said, "No; at 4:00, the shift will change." It is just unbelievable.

I talked to a mother whose ten-year-old son was offered drugs.

What we have to do is, clearly, work on three things: enforcement, education and treatment. On the enforcement side, one of the things that Senator Biden just mentioned was the use of drugs in prisons. One of the things that ought to be routine is drug testing before prisoners are discharged. One of the things that is not happening in the Federal prisons, Mr. Chairman, is that we do not have routine drug testing before people are discharged from our Federal prisons. That is one of the things that ought to take place.

Second, when people are found guilty of trafficking in drugs, they ought to stay in prison while they appeal. We don't want to deny anyone the right to appeal.

In Cook County—now, this is State rather than Federal—but in Cook County last year, over 900 people were found guilty of felonies, not just minor charges, but felonies, on drug trafficking, posted bond, and never were seen again. I think we can do much better on the law enforcement side.

Education—clearly, we have to do more. And I regret that the drug czar when he was Secretary of Education called for a 50 percent cut in drug education. There, clearly, we have to do much better.

Treatment—here are the precise figures, incidentally. In 1988, misdemeanors, 73 people who were found guilty of drug misdemeanors posted bond and did not show up; 919 in Cook County posted bond after they were convicted of drug felonies and then just disappeared. We have to do better than that. And I am not picking on Cook County, because I think you can find some pretty dramatic statistics elsewhere.

Treatment—you have to wait three to seven months in most urban areas in this country today if you are an addict and you go in and say, "I want help." We clearly have to do better.

And then finally, we have to do better in one other area where your Senator has been a real leader, Governor, and that is we can't just talk about it; we've got to fund these things. We pass great legislation, and then we don't fund it. Joe Biden, to his credit, had a bill up here two months or so ago to have an increase in the cigarette and liquor tax to fund the anti-drug program. As long as we make great speeches and pass great legislation and then do not fund it, we are just not doing what we ought to be doing. I think it is absolutely essential that we put some muscle behind our talk, and we haven't been willing to do that up to this point.

I have no further comments, Mr. Chairman, and look forward to hearing the Governor.

Senator BIDEN. Governor, I think there is a reason beyond your expertise, your interest and concern that it is important that Governors come down here. It is probably the only time in your tenure that you have to listen. And we appreciate your taking the time to listen to us, and we are very anxious to listen to you and maybe be able to ask you some questions.

STATEMENT OF HON. MICHAEL N. CASTLE, GOVERNOR, STATE OF DELAWARE, AND CHAIRMAN, NATIONAL GOVERNORS' ASSOCIATION COMMITTEE ON JUSTICE AND PUBLIC SAFETY

Governor CASTLE. Well, Mr. Chairman, I am very pleased to be here, and we are very proud of your leading this very significant committee. And Senator Simon, as you probably know, all the governors are going to be in Chicago for the National Governors' Association meeting starting this weekend, and I will try to stay off the street corners that you mentioned in your address to us today.

Senator SIMON. Great.

Governor CASTLE. I would like to thank you for providing me an opportunity to testify on this extremely important issue of drug abuse and its impact on our criminal justice system.

I am appearing before this committee not only as the Governor of Delaware, but in my capacity as the Chairman of the National Governors' Association Committee on Justice and Public Safety.

As a former prosecuting attorney and as a governor, I have a keen interest in the operation of our criminal justice system. I am concerned about the increasing number of prisoners in our system, about the crimes which have put them there, and the fact that we have done too little to consider alternatives to hard time in maximum-security institutions.

The drug problem has dealt a blow to our overall criminal justice system. Our courts are clogged with extensive backlogs; prosecution caseloads have doubled in many jurisdictions; our police find themselves in many instances outmanned and outgunned in dealing with the drug traffickers.

One urban police chief recently estimated that his department spends 80 percent of his time trying to enforce drug laws. He characterized the fight against drugs as "one long glorious failure", with courts overflowing with drug cases and violence in the streets.

The impact that the drug abuse problem has on the criminal justice system in general can be demonstrated by what recently took place in my State of Delaware. The State legislature enacted sub-

stantially tougher anti-drug legislation, some with mandatory minimum sentences. For example, a trafficking conviction can now be obtained with possession of only five grams of a narcotic substance and carries with it a minimum penalty of three years in jail, which is possibly the stiffest sentence in the Nation for this crime. The other day, I asked somebody what a gram was, how do you really determine what a gram is, and I now know what it is. This little package of "Sweet and Lo" is exactly one gram. And we are talking about possession of five grams of a narcotic substance will put you in jail in Delaware now for three years—which is hopefully a lesson to some people and will reduce some of the crimes that we are concerned about.

Because of my concern with the drug problem, I signed the legislation even though I fully realized that it would have a significant impact on the criminal justice system.

From this piece of legislation, we will see an increase in arrests and convictions for trafficking. By turning simple possession into trafficking, we will clog our courts with new cases. We will make it more difficult to obtain plea bargains, because defendants will not agree to a plea that involves a mandatory sentence.

Thus, not only will our prosecutors and public defenders be called upon to try more cases, thereby placing an increased demand on those departments, but our judicial system will be impacted due to the ever-increasing number of cases going to trial.

Of course, the final major impact of this legislation will be felt in our Delaware prison system. I recently agreed to build a new 600-bed prison to reduce crowding in existing institutions. This assists us in dealing with the threat of the court taking over our prison system. But as things are now, we may be planning a new prison even before the 600-bed one is completed.

There is no question that drug abuse is the single most important threat facing our society today. We must act immediately and decisively in attacking and eradicating this scourge.

But Mr. Chairman, as many of my colleagues realize, we must act before the problem reaches the criminal justice system. We must try to prevent these problems from occurring. In fact, it is most important because it is cheaper and easier to handle at that stage. We must then set our sights on the prevention and education aspects of the problem. Even thought the focus today is more on enforcement, it must be mentioned in this context, because I believe that this will be the key to ridding the Nation of this scourge.

We should aim our prevention efforts at every age group, starting with prenatal care for mothers, day care, mandatory drug education for our elementary and secondary school students, and continuous community education. Our ultimate objective is changing society's attitude and tolerance for drug abuse.

Senator Biden, as you know, when President Bush visited Delaware in March, the program he saw with you and me was WCASA, or Wilmington Cluster Against Substance Abuse. The program teaches self-esteem to inner city youth and offers alternative activities and positive role models for the entire community. It teaches them alternatives to the use of drugs and builds an awareness about drugs and their destructive power.

WCASA and other programs like it across this Nation tell me that we need to build community awareness of the magnitude of the drug abuse problem. It is quite interesting that community awareness and health education have changed our attitude about smoking cigarettes. We can now eat in a smokeless restaurant, take a smokeless flight across the country, and work in a smokeless environment in our offices. Now, I ask: Why can't we have the same type of campaign and attitude promoted about drug abuse? We must explore this if we are to get a handle on this problem.

Along with changing community attitudes in terms of prevention, we must increase public awareness, especially with our State legislators, about the costs of rescuing our society from drug abuse. This won't be cheap, but the alternatives are far more expensive. We could lose an entire generation of our youth if we don't act now.

It seems that when we fail to deter individuals from engaging in criminal activities, the basic alternative is prison. Currently, our Federal and State prisons are approaching 700,000 inmates. This represents an increase of over 90 percent since 1980. To accommodate this continued increase in inmates, we need more than 800 new bed spaces per week, which could cost on the average of $60,000 per cell. Today, many State prisons are being operated in an over-capacity status and are under court order because of overcrowding. As you have indicated, Mr. Chairman, roughly four out of five State correctional systems are under court order.

Delaware is not unlike the other States when it comes to overcrowded prisons. In 1984, drug-related sentences and admissions ran a distant second to sentences and admissions for assault. Since then, total admissions increased by 51 percent; but drug-related admissions have gone up by 462 percent. For the past 14 years, we have been suffering from chronic prison overcrowding, exacerbated by the fact that we have historically been among the top ten States in per capita imprisonment.

So what is the solution? Simply building more prisons did not work in Delaware, and it does not seem to be working across the Nation. As one of our Delaware judges very succinctly remarked, "You build them; we'll fill them."

What is our answer? First, since we have had this major increase in incarceration for drug violations, we must do something with this population while they are in prison. Dealing with the inmates while they are in the institutions just might be the key to solving the prison crisis, because sooner or later the overwhelming majority will be released.

It is estimated that over 50 percent of the inmates in prison today will have been released by this time next year. Will they be prepared to function in society, to get a good job and support a family in our highly technical society? If we do nothing, they will return and continue on the path of drugs and crime. We must then see that good substance abuse programs are implemented in prisons.

I would like to emphasize that I said "substance abuse", because I understand that the greatest drug of abuse which sends many inmates to prison and causes much damage in our society is alcohol.

One good program we have in Delaware to deal with the drug-dependent incarcerated offender is the KEY program. I understand that you will hear more about that program today, so I will not elaborate. However, I must emphasize that there must be more done to treat drug-dependent inmates in the prison setting.

Second, there must be education and prevention programs about the dangers of drugs given to both the inmates and staff. We must also see to it that our prisons are drug-free. I was chagrined to learn during a recent meeting of the National Governors' Association where several gentlemen who had been users of illegal drugs appeared before my committee, and one who had been incarcerated for over 30 years related that drugs were very easy to obtain in prison. The other former drug users who had been incarcerated echoed this with: "Anything you can get on the outside, you can get on the inside," meaning in prison. How can we rehabilitate these individuals when they have a continuous line to get drugs?

Third, educational and vocational programs must be established in prison in order to give individuals skills and self-worth. I know this is an old story that you have heard before, but the overcrowding in our prison systems has diminished the monetary and human resources for these programs.

It is estimated that 75 percent of the inmates in prison are functionally illiterate, and over 90 percent will be released back into the community still illiterate. Therefore it is essential that program to teach reading and writing to inmates be established, or in many cases, re-established.

Finally, I believe that we must expand our approach to sentencing alternatives. Certainly, big-time dealers must be dealt with in the harshest way possible, but we also need effective ways to deal with the little fish we catch in our nets. And I would argue that different approaches are necessary. For example, we should not punish the users of small amounts of drugs as we would those who are major traffickers, but they must be held accountable for continuing the market for the major drug dealers.

In searching for new alternatives in Delaware, we created the Sentencing Accountability Commission, or SENTAC. SENTAC identified four primary goals for corrections: 1) incarceration of violent offenders and drug traffickers; 2) diversion of nonviolent misdemeanor offenders into less-expensive alternatives to incarceration; 3) restoration of the victim, and 4) rehabilitation of the offender.

Through the efforts of SENTAC, two years ago, Delaware's legislature officially established a five-level continuum of sanctions which are designed to make the punishment fit the crime and at the same time allow us to control the cost of corrections. Those sanctions range from Level I, which is unsupervised probation, up through Level V, which is 24-hour incarceration in correctional facilities. Only those violent offenders and drug traffickers who present a real threat to the community are given the Level V sanction.

Other offenders are given varying degrees of supervision in Levels I through IV, including electronic monitoring, house arrest, and supervised drug treatment programs. The costs of alternative

sanctions below Level V are far less than the costs associated with housing an inmate in one of our correctional facilities.

Many other States are experimenting with alternative sanctions. Some are using boot camps, which you mentioned, or shock probation, and some are using programs such as Treatment Alternative to Street Crime, or TASC. I am not familiar with all of those programs, but our NGA staff and the National Criminal Justice Association are completing a review of State activities in this area, and it will be available in early September.

In conclusion, Mr. Chairman and Senator Simon, we all must understand that there are not easy solutions to the problems of drug abuse and prison crowding. Many people who use drugs have developed their habit over several years, and it cannot be broken overnight. A prison space alone will not solve their drug dependency. Therefore we must attack the drug problem on all fronts—through education, prevention, treatment and efficient and effective correctional policies. States are developing programs along these lines to deal with the drug abuse problem.

The Federal Government should allow States to develop drug control programs that are based on the States' assessment of the drug problem. After this assessment, the Federal Government should facilitate the implementation of the States' drug control programs with funds, technical assistance and equipment.

The Federal Government's quest to develop a national drug control strategy must take into account progress that has been made by the States. Coordination and cooperation among State, local and Federal agencies has increased because governors have assumed active leadership roles in developing and implementing statewide efforts to control drug abuse and trafficking in their States.

Governors want to see that adequate and comprehensive planning is done to ensure successful implementation of any proposed strategy in their States. The Federal Government can make an important contribution in accelerating implementation of comprehensive statewide strategic plans by promoting the Federal, State and local partnership needed to make an impact on the drug abuse and trafficking problem in this country.

Thank you, Mr. Chairman, and I'll be pleased to answer any questions that either of you may have.

The CHAIRMAN. Governor, thank you very much.

I have a number of questions, but because there has been such cooperation between the offices, I think I know the answers to a fair number of them—but some should be placed on the record, and others, I'd like to explore de novo with you, and I will not take a lot of time.

Let me begin where you left off. As I indicated, I think there are six or seven standards against which our national drug strategy should be measured. One of them is this criminal justice crisis in America and what is done to alleviate it. Another one is funding. We are going to hold a hearing on funding alone, how do we fund whatever we come up with. We have come up with a pretty good drug bill, which the President has refused to fund, and we have refused to force him to fund it, both Democrats and Republicans alike.

Another area is research and advancements in the treatment of drug addiction. There is a lot going on. I have met with a number of people who are, as they say, on the leading edge—some of whom, I might add, are in our home State, with the DuPont Company.

The third area is military role in interdiction of drugs, if that has any value, and what value it may have.

The fourth is what meaningful education programs are available to deal with drugs. You indicated that we have smokeless portions of restaurants and smokeless rooms like the one you are in right now, and smokeless airline flights. We have seen some changes come over America, but we have not figured out quite how to transfer that to another type of addiction.

And the fifth area that I am going to be holding hearings on, that you and I have spoken briefly about, is that concerning the media and sports. We have met with some of the network CEOs and heads of major studios, like Paramount, and we will be having some of them in. An interesting little phenomenon—a former CEO of one of the three major networks, who works on a committee that I set up on another matter, said to me, you know, we found something interesting. Back when you fellows—and it was before I got here, but I hadn't thought about it, to tell you the truth—he said, back when you fellows and women in the Congress passed a law, saying that if we are going to have cigarette advertising on TV, we had to provide an equal—I think it was an equal amount—of time for anti-tobacco ads on TV. He said, when I was CEO, we thought we were pretty sharp; we put all the paying tobacco ads, for the Lucky Strike and Camel and Marlboro and all the various other brands I can't even name, on prime-time; big revenue producers. And we took all the ads that were anti-tobacco, and we put them on Saturday morning during the cartoons and at times when we thought people were not watching TV except children. And he said although I don't have any empirical data, it seems to me it is somewhat coincidental that the generation that stopped smoking the most and has led the effort has been those people who grew up, who were in their adolescent years during the late Sixties and early Seventies. And one of the things we are having studied is that very phenomenon, to determine both if the media can play a part and, I might add, whether or not education makes a difference and at what ages it makes a difference.

A lot of it starts with funding—and this is my question. The Federal Government has made a major commitment to you governors to the tune of $275 million. At the end of October of last year, we promised that this fiscal year, you would have $275 million which you could break down several ways; it could break out to 1,000 drug units through the country, it could break out into education programs, a whole range of things.

We have not sent you any of that money, because we have not funded it, as you are aware. So you ended by saying that you thought the Federal Government had a role of both providing some money and some leadership. Would you elaborate a little bit on what role do you think the Federal Government has; how should the Federal Government fulfill that role? Should it basically send money—and I'm not being facetious when I say this—to the States and let them make the decision as to what are the most innovative

programs; or should it decide what are the most innovative programs around the country and then suggest to the States that if they wish to participate, these are the ways they can participate, and they will get money if they use those programs?

How would you governors like to see the money that we promised and haven't sent if and when it comes?

Governor CASTLE. First of all, I have total sympathy with your monetary problems. I realize what you all are up against. And I would suggest that you do not send money that you do not have. We clearly do not need an extra tax burden—although I must say that you are on the right track, in my judgment, if you are going to task the areas of cigarettes and alcohol, which are so closely related to habitual usage anyhow, would be the right areas to draw money from if extra money were needed.

As far as—and governors say this time and again; we say it about highway programs, we say it about environmental programs, we say it about the welfare regulations that are under consideration by Health and Human Services now, and I will say it here—that is that we would like as governors and people who are enforcing this, be they police agencies or drug-related committees or whatever it may be in the States, to have as much flexibility as we can have in the programs that come down to us.

Now, I understand the need for accountability, although sometimes accountability can get in the way of something which is good. And I would suggest that there are a couple of ways of getting to the flexibility issue. One is to present a menu of programs, for example, the ones that you and I are familiar with—the WCASA program, for example, is a prevention program for youth; the KEY program, which you are going to hear about later today; the program with the paramilitary prisons, which is certainly fascinating to all of us—we don't know yet if it is going to work or not—but there are probably 20 or 30 or 40 programs that with time can be developed. As I said, the National Governors are putting together a list of all those, and we will supply that to you when we have it ready in September.

But I think the flexibility to pick and choose a little bit is important. I think it would be wrong for the Congress to say here is the best program, and we're going to give you $275 million or some sum of money for a particular program, and say that all the States must do this because it seems to work so well.

I just do not think we have identified in this country what is really working and not working. For example, our KEY program, as you know, involves 20 people, Senator, in our prison system who live a very straight life. They make sure everything is clean, they have a ranking order in terms of how they do things, and they all have assignments and jobs. It is wonderful to see. We almost took the President to see it, but we didn't think it was fit to have the President in a prison, so we decided to show him another program.

But in any event, that program is something which we think works very well, but we don't really know. We have others, I think, in Pittsburgh, and some people have been released, but very few have been released from our system. So it looks good, but we don't know yet if it works. I think that is true of a lot of these programs. Some of these programs are really new. So I would stress flexibility

and constant review to see if these programs are working, with the elimination and adding to what is there. I think in that way, we can do the most good with the least money, possibly, and also accommodate differing circumstances. California may be a lot different than Delaware, which may be a lot different than Vermont than, say, Louisiana or whatever it may be. In that way, I think you can do the most in terms of accommodating all the States.

The CHAIRMAN. When we drafted the drug bill, one of the things that was at issue was how to distribute what has become phantom money, but we had made the commitment, and we thought we were going to get the cooperation to actually have the money. And there was a debate about how that $275 million for State and local purposes would be distributed—by what formula—and whether or not—and this is an unusual question to ask the representative of the National Governors Association—but whether or not some of that money could or should go straight to larger cities, the argument being that just as States differ, circumstances within States differ a great deal, and certain large cities should not have to go through the legislative process within the State because of time and because of parochial interests that occur. Now, I don't know whether you can answer that question, but as a matter of general principle, does the same principle apply that just as State officials know better what their local problems are than Federal officials, that within State jurisdictions, some municipal officials, mayors, may be better-equipped to more swiftly deal with their particular problem relating to drugs in their communities and should qualify directly?

Governor CASTLE. I believe this—and you could argue it either way—when you look at Baltimore, Maryland, or Chicago, or New York City or whatever, you could argue that certainly those are such separate jurisdictions and so vague that they need to make their own decisions—and I believe in that to some great degree. However, I also believe that one of the ways we need to attack this problem is to make what we are doing more public. I need to let people know in Delaware if they have five of these packets filled with narcotic drugs, they are going to go to jail for three years. I've got a hunch that is going to turn some people off, or some of the social users off from using that kind of thing.

We need to let people know what is happening, and I think one of our concerns is that we do this in such a broad way that people do know. And I think from that point of view that keeping this on a State level at least initially would be very, very helpful because then each State will do what we have started to do in Delaware. They will form statewide committees that will involve the local people and make sure that the programs are being carried out on a broad basis, with broad public knowledge of what is happening and the fact that we are attacking the problem.

However, I have a great deal of sympathy for the big cities—and I don't know how you handle that funding; I guess the funding formula would have to set up something that would let it flow through to the big cities—but I would argue that if you are going to give money to a State that has a dominant city in it and has an urban inner city problem, even though the problem spreads to the rural communities, too, as we know, but if they have that circum-

stance that perhaps there should either be a flow-through mechanism or some mechanism to make sure that they are not going to be left behind and in turn are given some flexibility in terms of what they are doing.

I don't think that flexibility just extends to the State program. I think the States should be mandated to give some flexibility as it goes further down to individual jurisdictions within the States. But I would start at the State level with some built-in flexibility to get it out to those other levels. I think that way you will have fewer coordination problems, and you will get more bang for your dollar.

The CHAIRMAN. I have one last question, Governor. I realize that you in all probability will not be able to answer for the governors, but one approach, as I indicated, that I am considering as chair of this committee is taking part of the $1 billion that the President has called for to build Federal prisons and use it to establish regional prisons that would house and treat both Federal and State prisoners, who are drug offenders.

Now, we are going to hear a good deal more testimony on that over the next six weeks and beyond, but what do you think of the idea, if you have an opinion, of having a regional prison, paid for by the Federal Government, that would help alleviate some of the crowding problem and take some of the drug offenders out of your system and put into a system that was specifically designed for the purpose of treating drug offenders and incarcerating drug offenders.

Governor CASTLE. Well, you are right about one thing; I can't speak for all the governors in trying to answer this, nor do I ever attempt to do that anyhow, but I can speak to some of my own thoughts about that.

You know personally what I have been going through in trying to locate a prison in the City of Wilmington. Locating prisons is very, very difficult unless you have very rural areas, and the States that are impacted—and we are the eighth-most, I think, impacted State in the country in terms of population per square anything, mile or whatever. And when you have that kind of a circumstance, it is just very hard to locate prisons. So I say somewhat tongue-in-cheek, if you are willing to locate prisons, I am all with you. I doubt if we can get it done in Delaware.

But I think, more importantly, the concept of what you are talking about makes some sense for a couple of reasons. One is I have thought often that maybe one of the areas that we need to turn to—and this becomes a monetary problem—is more specialized prisons. We have a tremendous alcohol problem in our prison system. In fact, Bob Watson, who is our Prison Commissioner and who is very respected in the country, has said that alcohol may still be a greater problem than drugs, which I alluded to in my testimony.

I think some specialized prisons may be in order; a specialized regional prison that could handle drug offenses from the Federal or State level would be something that would be well worth looking into.

I'll give you an example, and I am not sure how this works. In Wilmington, as you know, we follow cars—actually, our police go up to Philadelphia, and there is a certain section of Philadelphia

that they wait in, and they watch cars from Delaware pick up drugs, and then they follow them back to Delaware, and stop them and arrest them. It is routine; they never miss; they always manage to make arrests in that particular circumstance. This is sometimes done with Federal money, and with State police, and they go to Federal courts, sometimes. I am not really sure who has jurisdiction over those particular prisoners, or where they end up, or how they are even paid for, for that matter.

So there is a lot of overlapping right now, and I think we need that; I encourage that. I would never want to say that's a Federal program, and the States shouldn't help. I think we need to work together on these things. So that concept makes some sense to me.

I think the public has spoken very clearly. If people commit serious drug trafficking offenses, they need to spend some time in prison. We are kidding ourselves if we think we can get such alternatives in place that we don't have to build prisons. We are talking about deterring the growth factor in prisons, not reducing growth in prisons. There is just no way in the world we are going to do that.

So the concept is—and I had heard it before I got here today—the concept is enticing to me personally as a governor, and it is something that I think should be explored, and I would hope that your hearings would bring out more about it. If there is opposition to it, I don't know where it should come from or what it should be. I think the concept makes sense.

The CHAIRMAN. Thank you, Governor.

Senator Simon?

Senator SIMON. Thank you, Mr. Chairman.

Governor, this drug problem affects us in so many ways. Just yesterday, I held a hearing in Springfield, Illinois on special education, and it was said that we are going to have some additional problems in special education because of AIDS children who were infected through their mothers who usually got infected through the use of drugs.

One of the things you mentioned that I really appreciate, and you are right on target, is the whole literacy thing. There is just no question that for people who do not have the kind of self-esteem, who do not have options in our society, the option of drugs becomes a very easy and attractive way of making a living.

In our prisons today, a majority of prisoners go in without the ability to read and write, and they come out without the ability to read and write. We have to do something about this literacy problem.

It is interesting that the U.S. Attorney in Chicago, a man who is in law enforcement, and leads a drug task force says the real key to the drug problem is education. He has instructed one of his attorneys on the drug task force to work only on education issues because he thinks we are doing such a terrible job in that area.

We are spending somewhere between twice as much and six times as much on the enforcement end as we are on the demand side. And as I talk to people who work in the drug field, I think it is very clear that we are going to have to do much more on the demand side.

Finally—and I guess I am reacting rather than tossing questions to you—one of the questions I ask when I speak to high school groups is: How many of you have had your parents talk to you about drugs in the last year? Not very many hands are raised.

This cannot just be the State of Delaware and the United States Government. It has to be all of us working together.

Senator Biden mentioned the drug issue and the impact on cigarettes, and you referred to it, Governor, what is happening in cigarette consumption? I think we need some kind of a massive program by our networks in the area of anti-drug education—and it cannot just be half-time during a football game. It has to be reaching those children on Saturday morning cartoons. It has to be really much more penetrating than it has been up to this point.

I am giving you a lecture here rather than questioning you, but I would be interested in any reaction, Governor.

Governor CASTLE. I could give you another whole speech if you get me going on these subjects, Senator. First of all, I agree with you completely. I believe we have gone about as far in law enforcement as we can go. These laws that we have adopted in Delaware are tough, they are really tough, and we are going to be putting people in prison, and have been putting them in prison. Those statistics do not apply to a small State like Delaware where we solve crimes and report crimes and that kind of thing.

So the law enforcement side of it—we are equipped, we have police out there, and we are expanding our courts, we are doing those things—and yet that doesn't change anything. We have about a 3 percent unemployment rate. We have a welfare program—and one of the reasons I mention the welfare reform, something like 2,000 people have gone through it, and two-thirds of them are now working. These people have been on welfare for ten years. We have no problems putting people to work if they are willing to go through this and be trained, and we have not begun to dent our prison population. Crime expands, the prisons expand, and that kind of thing, so there is something that is deeper than law enforcement that needs to be sought out of we are going to solve these problems.

I think that is very significant, and I don't mean to ignore it, but you are absolutely correct. We as a society need to absolutely understand that very early on, we have go to start addressing this problem. I mentioned, deep in the bowels of the speech that I gave, the concept of prenatal care, for example, which is vital; if you have mothers who are on drugs who are not getting proper counseling, it starts right there, and that is problem; and the early treatment of kids who are three and four years of age. We have kids, as you know, who are 10 or 11, who see this on television—you see the shooting and all the things that go on on television. I watched "Lethal Weapon" on the VCR the other night, and everyone is getting shot up. It is just wild what you see in these concepts. And I am not saying everyone swallows it whole, but if you are exposed to ten murders per show, and drugs being constantly used, if you see athletes who are using drugs who—let's face it—are generally the heroes of most of us as young people, young men and women now—it used to be just young men, but it is young men and women now—it is just one heck of a problem. And then you go onto the

streets, and you see the gold chains and the fancy cars and those who seem to be doing well and urging others to drop out at the age of 16 and make some money, and instead of getting $4.50 at McDonald's, you go out and do the running and do all those things that lead to the drugs.

We have just got to change that whole image. A heck of a lot of it, in my judgment, is television, quite frankly. What we see on television and the movies is just something which is abysmal, quite frankly, and it leads to this. A lot of it is the whole education structure—the parenting, as you mentioned; what we are doing in the child care centers, in the grade schools, in our junior highs and our high schools—and I think by then, it is pretty well in place, you either have it or you don't, in terms of what this means.

Len Bias' death made a tremendous difference in this country for a short period of time, but people are beginning to forget that now. We don't want heroes to die in order to have an awareness level raised. But we just have to do these things.

And the smoking thing is important as a concept, because today, almost everyone who smokes will ask before they smoke; they are almost embarrassed. Almost everyone who smokes will say, "Gee, I really wish I didn't smoke," and they are somewhat addicted to it or whatever the right expression is, so they continue to smoke, but they almost wish they did not. We don't have quite that attitude among a lot of users of drugs. It is sort of an experimental stage that you go through, and yet it is very dangerous and causing some tremendous problems for us. Just look at what is happening in Washington within yards, or certainly a few miles, of where we are right here in terms of people dying on the streets, and kids. The Washington Post had a headline today about a 13-year-old kid who was a leader, for goodness' sake, in his school who was involved in this.

So there are just all kinds of problems. And yes, it is worse when you get into poverty levels. It is probably worse when you are more impacted, such as big cities, although it is spreading all over the country now. But we need to understand that, and I think as a group of elected officials, we have to understand that, while we talk about mandatory sentences in prisons and those kinds of things, and they sound good, we have got to understand the social programs that can ultimately make a difference. We have got to talk to the people who can put those programs together.

Senator SIMON. Absolutely.

Governor CASTLE. I don't have the answer to all those things, but for God's sake, if we start to fund things and we start to do things, and keep our eye on that—don't let that get lost in the fervor to make sure we are doing so many of just the law enforcement things.

Senator SIMON. I appreciate your leadership, Governor.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Governor. I appreciate your coming down. I want to emphasize again that your admonition for us to keep our eye on the ball here and not get distracted totally on the criminal justice side is what we intend to do. As I said, this is just one of a series of six major areas we want to look into. It happens to be the first, and because you are a leader in this

area, this particular aspect of the problem, as well as the education and child welfare side, but in your capacity as the chair of the committee among the governors, that is why we invited you here.

I would like to ask further if you would be willing in your capacity to meet with some of us toward the end of September or early October, when we are literally passing on the national drug strategy, so that as we make some of the decisions here as to how we wish to react, alter, modify, accept, reject the plan that has been put forward, we do it not in a vacuum, but in conjunction with those of you who are actually attempting to and will be required to put in place both the law enforcement side as well as the education and treatment side of whatever national drug strategy comes forward.

Would you be willing to do that with us?

Governor CASTLE. I would be pleased and honored to do it. And I will volunteer one other thing. I will have the National Governors' Association group continue to forward to you and to whomever else you ask us to any information that we develop in any of these areas, because as we go along even before then it may be helpful to have that in hand.

The CHAIRMAN. I appreciate it, and I appreciate again your taking the time to come down. I know it is a long ride.

Thanks a lot, Governor, for coming. I appreciate it.

Governor CASTLE. Thank you, Mr. Chairman. It is good to be here.

The CHAIRMAN. Our next witness will be Thomas Coughlin. I am going to call Mr. Coughlin up now because he is the Commissioner of the New York State Department of Corrections, and the reason I am calling him separately is because my friend, Charlie Rangel, expects him to be testifying before his committee at 11:30—but as Charlie fully understands, Commissioner, his committee is not nearly as important as this, and I am sure he will understand why you are late. We will try our best, all kidding aside, to get you there as close to on time as we can.

Then we will have Mr. James and Mr. Wald come to testify before us.

But let me begin with you, Mr. Coughlin, and the shorter you keep your opening statement, the quicker we can ask questions, and the quicker we can get you over to the House side to do what we all have to do here—try to be two places at once.

Welcome.

STATEMENT OF THOMAS A. COUGHLIN III, COMMISSIONER, NEW YORK STATE DEPARTMENT OF CORRECTIONS

Mr. COUGHLIN. Thank you.

I'll be very brief—in fact, I will even bypass my opening statement. I have provided copies of the complete statement to the committee.

The CHAIRMAN. The entire statement will be placed in the record as if read.

Mr. COUGHLIN. Thank you. Let me just hit some highlights. We were asked to come up and talk about the impact of our shock incarceration program. I'd like to do two things. I'd like to just brief-

ly tough on shock incarceration, but also talk about a more substantive program that we have started in New York over the past several months that probably has more of a benefit for society than just shock incarceration.

Shock incarceration, or boot camp, as you have mentioned today, has been operating in New York State, interestingly enough since 1890 or so, when Elmyra Reformatory went to the military style of treatment of young, first-time offenders.

The current program which has been getting some notoriety has been in operation for about 18 months. I will say very briefly and very clearly: I don't know whether or not this is going to be a successful program, and I don't think it is appropriate to make judgments on its success or failure over its short 18-month life span. I think you have to look at this over four, five, and six years and then make some judgment.

I think in a prison system the size of ours, some different things must be tried, and this is just one of the different things that we are trying.

To date, the success of the program in terms of inmates coming back in is about the same as inmates who didn't get involved in the program; they come back at about the same rate. However, the fiscal implication of shock incarceration is tremendous. For every 100 graduates out of the program, the State saves approximately $1.5 million. So if you are getting the same result as a 22-month prison sentence with a 12-month prison sentence, it would seem that is food for thought in terms of using the program more frequently.

We have made a judgment in our State to go into the things that were talked about by the earlier witness, and that is specialized prisons. We have tried some residential drug treatment programs in the prisons for the past four, five and six years. We have decided this year, with a major expansion in the prison system, that almost 50 percent of the new beds, almost 2,000 new beds, will be allocated toward residential drug treatment, with a very interesting caveat: The drug treatment program to be provided in these new prisons will be provided by outside, not-for-profit groups. Now, that is not to say the prison system cannot do it; but there is a key. If you can have a person drug-free and in treatment while he is in prison, you must have a carryover when he leaves prison. And the not-for-profit providers in the street are the front line in that provision of treatment services. Involve them in the prison program; require them to provide relapse and follow-up services on the street, and I think you start to put together a continuum of drug treatment for offenders.

I will be more than happy to answer any questions that you have.

[Prepared statement of Mr. Coughlin follows:]

Statement of Commissioner Thomas A. Coughlin III,
New York State Department of Correctional Services

Senator Biden, thank-you for the opportunity to appear this morning before the Senate Committee on the Judiciary.

All of us know we are in a war – against drugs.

What doesn't get sufficient notice sometimes is the fact that, like it or not ... despite the billions we have spent ... we are losing that war.

We must explore new avenues to address drug addiction and recovery, or we will continue the revolving door of arrest, incarceration and parole, to surely be followed by re-arrest.

In New York, we were among the states to pioneer the concept of *shock incarceration*. We are today on the threshold of instituting yet another unique approach to drug treatment in prison, tied to aftercare on parole. It is these programs that I want to discuss this morning.

But I will begin with a caveat: There are no perfect solutions, just as there are no instant answers. There are only appropriate punishments and alternatives that we haven't tried yet.

I remember attending the first inmate graduation from *shock incarceration* – boot camp – a few years ago. I watched as tears streamed down the face of the platoon salutatorian. I listened as his voice broke, while extolling the virtues of shock and all it had meant to him.

He's back in jail. And I ask this select committee to remember that – every time we try a new program, or a new approach – there will be failures. But we should look beyond the anecdotal failures and focus our efforts upon our thousands of successes ... and what works.

Because I believe our role as public servants requires us to examine and maybe even try every sound idea that we think might turn things around, and help us to start winning this war.

Because what is at stake is our future. And what we face losing is America's most precious resource – our children and our young people.

Let me begin with our experience with shock.

Our early experience with shock has shown us two things that suggest we might be on the right track:

- Inmates who complete shock return at a rate of 17% compared to 25% among all inmates. That is significant because each 100 successful shock releases saves taxpayers $1.5 million.
- Inmates who complete shock return at the same 17-19% as do inmates who were eligible for it but chose not to participate. That means the return rate for inmates who are in shock for only six months is the same as for those who spend an average of an additional eight months in prison.

The purpose of prison has traditionally been the secure confinement, rehabilitation and segregation of felons.

That thinking has changed in New York State. We do not believe in rehabilitation.

Because one definition of rehabilitation is "to restore and to improve its original state."

Why would you want to use prison to turn out a better class of drug users and dealers?

Governor Mario M. Cuomo endorses that concept of habilitation.

Most people in prison were never socialized in the first place. That ignorance of how to live in our society contributed to their criminal activity.

Our goal becomes one of habilitation. Now we are attempting to showcase that philosophy.

The six-month shock regimen includes more than just the 500 hours of physical training plus drill and ceremony that has led to the media dubbing it a "boot camp."

It also includes 546 hours of the therapeutic approach to treating addiction, based on the *Network* program and in Alcoholics Anonymous' *12 Steps to Recovery*. It also includes at least 260 mandatory hours of academic education, and it also includes 650 hours of hard labor, working on facility projects, community service work and projects in conjunction with the Department of Environmental Conservation.

Of nine shock-type programs surveyed, New

York's is the only one where:

- Staff is required to undergo one month of shock-type training before inmates arrive, so that all staff, superintendents and clerks alike, are aware of both the content and goals of the program;
- The program includes an intensive therapeutic community approach to habilitation, and
- Inmate graduates undergo a full year of intensified parole follow-up.

We believe successful completion of the six-month regimen results in inmates becoming better people. And they get out of prison as much as two and one-half years early. Failure means serving a full sentence in prison.

But the choice is their's. As attractive as that may sound to some, 56 percent have found the regimen too demanding, even with the carrot of early release.

Many have already chosen to leave and to complete their sentence in a traditional prison.

Our latest numbers show that of the inmates eligible for shock incarceration, 44 percent either did not apply for the program, or applied and were found medically or psychologically unfit.

Through July 8 of this year, 5,230 inmates had been screened for the program, 1,951 have entered it and 831 have graduated; 597 remain active in the program, while 523 have transferred out, including 320 "washouts" and 173 have left at their own request.

But for those who volunteer, successful participation in the program is defined as:

- Learning how to live without committing crimes against others or their property;
- Having enough respect for yourself to take control of, and be responsible for, your own actions;
- Disciplining yourself to seek realistic goals through your own honest efforts, and
- Developing socially-acceptable tools to succeed: education, work ethics, job skills and whatever therapy or counseling might be needed in an individual situation.

Most inmates neither possess nor respect such abilities.

So our goal is to offer to habilitate them:

- In a program running from 5:30 a.m. to 9:30 p.m.
- Six days a week.
- With a full three hours of free time – each and every Sunday.

The treatment component, which differentiates our program from most others, is extensive.

Governor Cuomo does not believe we can turn someone's life around simply by making them do push-ups, march in formation, or simply by taking orders.

The strict physical regimen is a pivotal tool in teaching discipline and respect for authority.

It is also an excellent means of challenging individuals, as well as teaching them about teamwork and getting along with others.

But of equal importance and weight in our program are the components that deal with education, professional and peer counseling, plus drug and alcohol therapy.

Network therepeutic community meetings, with staff and inmates working in sometimes confrontational dialogues, are held for one hour each week day. There are also sessions designed to teach decision-making in socially acceptable ways, which run for two hours each week. For four hours per week, group meetings focus on problem-solving, confrontation and conflict resolution.

Here's how one inmate described *Network* in a letter to his family: "Here they also have a thing called the Network program. You might have heard about it. It helps you learn more about yourself and understand different things better."

Individual counseling, as required, takes up another hour per month – more if required.

Pre-release programs, designed to help inmates make the transition from prison to parole, require two hours each week.

The daily program at each facility includes two to three hours of physical training. That includes military-style drills, calisthenics and a 2-3 mile run. For seven hours each weekday, inmates are involved in labor-intensive work projects.

They perform community service projects in neighboring towns and villages; they also cut trees

and clear brush for the state Department of Environmental Conservation; they work on construction and maintenance at the camp itself.

A full day each week is devoted to education, including high school equivalency diploma courses, remedial education and other academics. Education courses are also held week nights.

It is the combination of these programs that we believe offers young offenders the chance to get their heads on straight and their lives in order. Traditionally, we sent felons to prison as punishment. Now we send some young offenders to shock incarceration, in hopes of helping them become good citizens.

There are weekly assessments made of each inmate in each program category, and monthly reviews are completed by a committee that includes Division of Parole as well as by Correctional Services' personnel at the shock facilities.

Eligibility requirements are different for inmates up to age 26, as opposed to those from age 26 through age 29, the cutoff for participation in the program. New York is one of only two staes in the nation where the Department of Corrections selects among eligible inmates for participation in the shock program.

For inmates who are less than 26 years of age, they are eligible if:

- They are physically and mentally qualified;
- This is their first sentence to State prison;
- They are within three years of parole eligibility;
- They are not serving a sentence for a violent offense, such as murder, manslaughter or rape.

For inmates over age 26 but under 30, the rules are the same with these added restrictions:

- They cannot have ever been convicted of a crime that would keep them out of shock. (Inmates imprisoned for drug possession, for example, would be excluded if they had previously been convicted of a violent crime, even if they received a sentence of local jail time or probation.)
- The sentencing judge must not oppose their participation in shock.
- They must serve at least one year, including the six months in shock.

Throughout the nation, most other shock programs are contiguous with a medium- or maximum-security facility.

In New York, we are devoting entire, separate facilities to this program, with every aspect of their operations focused on, and supportive of, the shock program.

Each is located in a rural setting in upstate New York, with plenty of room for their dormitory-style housing units.

The rural setting is advantageous. The noise of marching and cadence calling, as well as physical training, does not disturb neighbors.

The 250-bed Monterey Shock Incarceration Facility opened on September 10, 1987, in Schuyler County. Its first platoon graduated March 8, 1988.

The 250-bed Summit Shock Incarceration Facility, in Schoharie County, began accepting males on April 12, 1988. Females entered the program on Dec. 12. Summit's first platoon of females graduated last month.

In April of 1989, the State's third Shock prison, also a 250-bed facility, opened at Moriah in Essex County. The first graduation at this facility for males will be on September 21, 1989.

On June 22, just about one month ago, a graduation of sorts was held at the State's fourth 250-bed shock camp. On that date, staff at the Butler Shock Incarceration Facility in Wayne County completed one month of training in advance of receiving their first inmates on June 26. As at the three earlier camps, Butler's staff spent a month undergoing training along the lines of what inmates will experience when they enter the program.

Staff inform inmates of the purpose and objectives of the program, describe a typical day and respond to questions. Eligible inmates are then offered the opportunity to volunteer for it. Upon acceptance, inmates receive a two-week orientation before the actual program gets underway. They are currently screened at our reception and classification centers.

That will change next month when the 750-bed Lakeview Shock Incarceration Facility opens at Brocton in Chautauqua County, making it the largest "boot camp-style" prison in the nation.

After Lakeview opens, reception centers will

transfer to Lakeview all inmates who are shock-eligible, whether or not they volunteer for it.

At Lakeview, inmates will be advised of the program. Those who opt not to participate will be transferred to traditional prisons.

Those who choose to volunteer will either join a platoon right at Lakeview, or be transferred to a unit at one of the four smaller shock facilities.

There were downsides to the program. I think they have been rectified as shock becomes a more familiar operation within our system.

Not surprisingly, those downsides concerned staff and inmates.

Traditionally, our camps like Monterey and Summit were havens for senior officers.

The camps housed inmates on their way out of the system, whose good institutional records allowed their transfers to these minimum-security facilities.

They were minimum risk inmates who wanted to do their time quietly without creating any problems: they knew incidents would land them back in a higher-security institution.

Those same officers today are faced with street-wise young offenders who are just entering the system, and have never seen the inside of a maximum-security prison.

Suddenly, these officers are seeing a flip-flop, where they are on the front end of the system.

With some of that older staff transferring out, they were replaced by younger officers, many of whom lacked the military back ground needed for the boot camp aspect of shock.

To help overcome that situation, we mandate four weeks of training for staff, to show them exactly what is expected in both the boot camp and programmatic sides of shock incarceration.

For inmates, many are opting not to volunteer for the program, because they think it is too difficult.

But inmates who have entered the program have had positive things to say about it:

"I want to say that this is a very positive program and that I am sure that it is going to help a lot of inmates that otherwise would've never had the chance."

"I think zero week (the first week of training) was the very hardest week of my life. Especially the jogging – it was rough on me."

"I think that shock will make me a better man and teach me how to deal with society and teach me a lot of discipline and responsibility. I think that the people that I hurt, when I go home, will be happy to see the change and will be happy of the man that shock has made of me, and not the man that I was before I came to jail."

Another inmate wrote, "I thought zero week was Hell and I ain't going to lie about it."

Parole staff begins their planning the day inmates arrive at the camp and begin that "zero week." As part of the shock program, Governor Cuomo mandated that Parole follow inmates closely upon release to see how they perform.

Parole writes a treatment plan and prepares a report to the parole field office which will supervise the inmate upon release.

Parole officers in the field developed an "after shock" program that includes individual as well as group supervision.

Caseloads are set at 30 parolees per parole officer. Parolees must meet with the officer twice weekly in their first three months after release, then once a week for the next three months.

During those first six months of parole, the meetings with parole continue the decision-making and conflict-resolution counseling begun in shock.

Parole monitors the inmate by making two home visits per month, ensuring the inmate retains full-time employment, or enrolls in an education or drug treatment program as warranted.

For the balance of the inmate's parole, the 30-to-1 ratio is maintained, but group sessions are thereafter run by counseling and therapy groups with mandatory attendance on the inmate's part.

So what does it all cost? The camps are designed to be operated for one year housing 500 inmates – 250 inmates in each six-month program – with a total budget of $5.2 million and a staff of 142. That's $9,000 to house an inmate per year, versus the systemwide cost of $20,000. By comparison, a 250-bed minimum-security camp would have 127 employees and a budget of approximately $4.9 million. Each are self-contained minimum-security facilities.

We must also realize that the savings of up to 30 months of incarceration for each successful participant is a sizable savings to taxpayers.

Diverting young offenders from criminal activity in a cost-efficient manner provides an even better return for the people footing the bill – the New York taxpayers.

But the biggest return to society, if we are successful, will come in the fact that, hopefully, these offenders will not return to their criminal ways and wind up back in prison.

We believe we are on the right track. Governor Cuomo is committed in his belief that punishment need not always take the form of incarceration.

Any state can build its way out of prison crowding by adding cells – at the cost of less money being available for tax cuts, highways, education and other programs.

Governor Cuomo has proposed many alternatives to incarceration, and shock is only one of them.

Young offenders can be diverted from criminal activity, if we offer them the chance of a productive life – and if they want to take advantage of it.

Governor Cuomo wants to reduce recidivism, not just cut the level of prison crowding. We hope shock will continue to help in that effort.

Our efforts to battle addiction does not stop with shock. We begin a major program later this year that builds upon what we have learned from shock and through 10 years of treating inmate addicts.

Six 200-bed Alcohol and Substance Abuse Treatment (ASAT) Annexes were authorized on July 11 when Governor Cuomo signed the *Omnibus Criminal Justice Law of 1989*. The annexes will be unique in two ways:

- This Department will provide security, administration and support personnel at each Annex, but outside non-profit organizations will be contracted with to come inside these prisons to provide residential drug treatment.
- Those providers will be required to sign contracts with the Division of Parole, guaranteeing each inmate an appropriate drug treatment slot in their county of commitment upon parole release.

Full implementation of Governor Cuomo's drug program will bring the number of new drug treatment beds to 2,150. It includes, in addition to the six 200-bed annexes:

- Authorization for a seventh Annex if the number of new prison commitments warrants it, and both the Governor and Legislature agree to appropriate funds.
- Appropriated funding for a 750-bed medium-security prison in which all inmates will be in the ASAT program administered by Departmental staff. We believe this will be the largest single prison in the nation dedicated to addressing drug abuse among felons. It will cost $65 million to build and $17 million a year to operate with 400 workers.

This addiction recovery program is intended to break the cycle of abuse by mandating a continuum of treatment: No longer will inmates receive drug treatment and enter recovery in prison, only to relapse on the street – in part because no one is guaranteeing them a treatment slot.

If parolees continue in recovery programs, they will not be committing crimes against our citizens to obtain drugs. Our taxpayers will not be spending $100,000 to build a cell for parolees to return to, and $25,000 a year to house them. The money can be spent instead on social programs, highways and bridges, tax cuts and to address other needs. But the process begins with breaking the drug cycle, in order for us to invest in the future of the recovering addict who has done time, as well as in the future for us all.

The *Omnibus Criminal Justice Bill of 1989*, among other initiatives, authorized the construction of 5,400 new prison beds – with 1,950 of them, or 43% of the expansion, earmarked for residential drug treatment. In signing it, Governor Cuomo noted that, "The police officers on the streets are making more and better arrests while the courts are making more and longer commitments to State prisons ... (this law) will allow us to build more cells and enhances our chances of deterring future crimes by the people who fill them. It is another major component of our effort to take back the streets."

The ASAT Annexes will address the two overwhelming commonalties among inmates: More than 70 percent admit to having abused drugs on the outside, while 80 percent lack the high school degree required to hold even some entry level employment.

Roughly 20 percent of inmates who successfully complete residential ASAT programs return to

prison, against a return rate of upwards of 30 percent among non-participants. Only 17 percent of inmates earning high school equivalency degrees return, compared to 25 percent among those who don't.

All 57 State prisons offer ASAT programs, while eight facilities also offer residential drug treatment, lasting 3-9 months, such as that to be offered in the annexes. The existing ASAT program costs $4.6 million annually, and serves 12,000 offenders a year.

200-bed ASAT Annexes will be built within the perimeters of the Marcy medium-security prison and the Lakeview Shock Incarceration Facility, one adjacent to the Butler facility, while the remainder will be free-standing units in Brasher, Chateaugay and Johnstown, distant from any other prisons. Each will cost $20 million to build and will cost $5 million a year to operate with 140 employees.

The therapeutic community approach to ASAT – in place at existing residential programs – will be duplicated at the Annexes. Inmates will be involved in intensive group therapy and individual counseling, as well as in the *Network* program. Academic education, to address the second greatest need among inmates, will also be compulsory.

Inmates in the program will be those within two years of parole eligibility whose prison adjustment and program participation, plus their crime of commitment, allow them the privilege of participating in Temporary Release Programs.

The organization providing ASAT will, as inmates develop a proven record of addressing their addiction, recommend that inmates be temporarily released to the drug treatment program that the provider believes will meet the need of the individual inmate upon parole – while allowing the provider to oversee the inmates readjustment to society prior to that parole release.

It should be clearly understood that inmates will be on temporary release: Such status is granted at my sole discretion, and I can revoke it at any time, and order the inmate returned to prison.

Unlike shock, inmates will have no choice as to whether they are sent to the Annexes for treatment. And they won't get out of prison one day early for successfully participating in a recovery program.

What they will have received, however, is a better chance for success on the street. That's their carrot.

That is all – and everything – that we must provide, if we are to break the cycle of drug abuse and crime among offenders.

The CHAIRMAN. Let's move to the area that you have been very blunt and straightforward about, and that is the so-called shock treatment or boot camp proposals.

I happen to share your view—if all other things like recidivism are equal, and the cost is less, then assuming you are doing no harm to the individual and/or society, it could be considered positive, at least for some people.

So your admonition to us, I think, is wise—we can't draw any firm conclusions from these programs, at least out of New York State, until we have had time to see how they work over a longer period of time.

But let me ask you about how you determine who qualifies for admission or sentencing to a shock treatment—or, I'll use "boot camp" only because it has gained currency down here, and like all new ideas that seem to have on their face some appeal, it is gaining maybe more currency than it warrants, and it may be promising more than it should as a possible alternative—I happen to think it promises more than it should, but we'll leave that aside for a minute.

The cost per inmate, you have already spoken to. For a similar period of time, assuming that you had someone in the shock/boot camp program and another person for the same amount of time in the prison system, incarcerated 24 hours a day, what is the cost differential?

Mr. COUGHLIN. It is probably just a touch more expensive for the shock program.

The CHAIRMAN. The shock program is more expensive.

Mr. COUGHLIN. For the same inmate in the same amount of time.

The CHAIRMAN. Yes.

Mr. COUGHLIN. The shock camp is staffed a little bit richer than the regular medium-security or minimum-security prison, and that is because there is a heavier emphasis on drug treatment and education with a smaller number of inmates. So it is a little bit more expensive per inmate per same period of time. But because the shock inmate only spends six months, and the regular inmate spends his full year, that's where the savings come out.

The CHAIRMAN. And at this moment, there is no evidence to indicate whether or not the shock prisoner released after six months is any more or less likely to be a repeat offender and/or commit other crimes associated with or not associated with a drug problem during the period of time he is on the street.

Mr. COUGHLIN. You can play games with numbers all you wish in this business of corrections. We tried to be very honest with this program. Seventeen percent of those who graduated from shock have come back to prison. Eighteen percent of those people who were shock-eligible, but didn't volunteer for the program, have come back to prison. Seventeen percent of the shock people versus 25 percent of the general population—so if you look at the general population at release, shock does better; but of shock-eligibles, those who went and those who did not go, it is about the same.

The CHAIRMAN. Let's talk about shock-eligible. What makes you shock-eligible?

Mr. COUGHLIN. You have to be between the ages of 16 and 30. You cannot have had a prior State sentence, so that it has to be

your first time in State prison. For the group 26 to 30, which we have a new legislative criteria for, you cannot have done any time in prison, namely, a local jail sentence. And you have to be convicted of a very narrow list of crimes, basically nonviolent types of crimes with some notable exceptions—criminally negligent homicide, vehicle homicide excludes you from the program.

So what you have is on average a 21-year-old young man and a young woman—we have women in the shock program—who is doing his first bit in a State prison and probably his first bit in any kind of incarceration, involved with narcotics—75 percent involved with narcotics, roughly 30 percent involved with alcohol—at the time of the commission of their crime, and individuals who are not high school graduates, have rather low reading and math ability, and who are at the age that you can deal with them, where maybe you can mold their minds for six or seven months and get them back on the right track.

The CHAIRMAN. Okay. What are the dangers—what admonishments would you have if you left New York and were asked to go to "x" State to set up such a system? What safeguards do you build in so we don't end up with the image that some people have of "Cool Hand Luke" and the "Man with No Eyes" standing over top of someone with a billy club, on a day when it is 104 degrees in the shade, making him do pushups?

Mr. COUGHLIN. I think that shock incarceration, or a shock program is a heck of a way to run a prison. I wish all 50,000——

The CHAIRMAN. "Heck"—good or bad?

Mr. COUGHLIN. A good way to run a prison.

The CHAIRMAN. Okay.

Mr. COUGHLIN. I wish I could take the concept and spread it out over my 50 other prisons. It is not a bad way to run a prison. There have to be some cautions, though, and that is what I think you asked about.

Every, single employee who is involved in the shock incarceration program, before he goes to work, goes through one solid month, four weeks, of specialized training. He goes through the same thing the inmates go through in terms of the therapeutic concepts and the military style of operation of a prison.

The CHAIRMAN. Including the same physical requirements?

Mr. COUGHLIN. Absolutely the same physical requirements. And that is just not the officers, by the way. It is from the cooks and secretaries through the officers, the sergeants, the captains——

The CHAIRMAN. Why is that important?

Mr. COUGHLIN. I felt it was extremely important to let the employees know how we want this thing to run, where to draw the line. It is not going to be a "Cool Hand Luke" operation. It is not going to be a brutal operation. It is going to be something that is professional, and here is how we want it done, and we are going to make you go through it first. So everybody goes through it.

And I would caution anybody who started a program like that to make that requisite, requisite.

The CHAIRMAN. What kind of medical screening takes place to qualify for the program—is there any?

Mr. COUGHLIN. Oh, there is a great deal of medical screening. In fact, probably 20–28 percent of our eligible inmates are excluded

because of medical reasons. You have to be in rather good shape to get into the program—no hereditary kinds of disabilities and no obvious medical or psychological problems.

The CHAIRMAN. If you are a first-time offender, which is essentially what you are saying is required, I guess you could have been convicted and put on probation and still qualify for the program.

Mr. COUGHLIN. That is correct.

The CHAIRMAN. But do you look to the extent and frequency of the drug or alcohol problem that the person carries with him, notwithstanding the fact it may be his first time? In other words, if this is the first time that John Doe gets caught, but we know from his record that John is a heavy user of any substance that would be otherwise classified as a seriously addicted person, is that a disqualifying or inclusive factor?

Mr. COUGHLIN. Oh, no—that's the disability that we want. We want the first-time offender who admits to or even if he doesn't admit to a serious drug problem. And we can usually tell within two days after he comes to the prison whether or not he has a drug problem. We want that individual in the program.

The military aspect of this program usually gets all the media attention, and that is unfortunate, because if you look at the breakdown of the hours and what an inmate does in that program, 500 hours are spent in military drill and whatnot; 560 hours are spent in drug treatment. So there is much more time spent in drug treatment than there is in the marching and so on.

The CHAIRMAN. One of the ways this boot camp notion has been advertised by some is that it may be particularly suited for the first-time offender who is not seriously addicted—I guess that is an oxymoron, "seriously addicted"—would not qualify as a heavy user of any drug and to scare the devil out of that person, so that they would leave their social habit of occasionally snorting cocaine at the party aside; they don't want any part of it again. I mean, that is part of the allure that is being suggested here. And what you are saying to me is that the ideal person you are looking for to try to get to is the serious user who this may be the first time they got caught, as opposed to the person who literally tried it for the first time.

You know, there are kids out there, there are young people out there who have "good" luck and "bad" luck—I guess it really is the reverse—and that is that the first time they ever try anything, they get nailed, as opposed to someone else who has been using for two or three years and doesn't get nailed until three years down the track. The idea of the first-time user, the person caught the first time, that's not really what you are looking to——

Mr. COUGHLIN. I think shock incarceration has more efficacy for the second offender. I wanted to allow second nonviolent felony offenders into the program. Unfortunately, the legislature in New York did not agree with me. But I still maintain that that kind of program has much more efficacy for the committed, long-term addict, especially the older long-term addict, than it does for some of the kids.

I think you'd see, if we ever can convince the legislature in New York to try it, better results with the 28- and 29-year-old committed addict who has been in prison a couple times for nonviolent of-

fenses, because they are about ready to turn around at that age. If you can give them some direction, if you can give them something to hang onto and give them the follow-up on the street, I think you have saved that person. If you just put them back in a regular prison——

The CHAIRMAN. You have struck on one of the questions I didn't intend to ask you, but I ask all of the, quote, "treatment/pharmacological" people and education people who have been advising me. I have been having about three times as many hearings in my office as I have here publicly with the people from around the country—and I am getting great cooperation—the so-called "experts" in all the various fields. And one of the questions I ask, and I will ask you now, is what is the prime age—when do you think is the best shot to take someone who is beyond the first-time user to get them to move away from it?

The image again is someone when they are 18, 19, 20 years old. You mentioned someone in their late 20s. Would you expand on that a little bit?

Mr. COUGHLIN. I think we have to do two things. We have to try with the younger person, with the 18-, 19-, 20-year-old person. We have to try with them. I personally, after 15 years in this business, think that you have a better chance with the guy in his late 20s, the 28-, the 29-, the 30-year-old guy, because he is tired; he has been around the horn; he has been in treatment programs. He is really looking more to say, "I've got to stop this; I've got to break out of the burglary and the drug use cycle that I am in." You'll find a much more receptive individual at that age than you do at age 20—but let's not say because we'll have better results with that guy, we stop with the 20-year-olds. You're going to save some 20-year-olds.

The CHAIRMAN. I'm not suggesting that. The question is whether or not it is worth the effort at that end as opposed to in terms of where you want——

Mr. COUGHLIN. I think it is worth the effort. That is what is wrong with criminal justice. You cannot pick and choose things. You have to spread out across the whole continuum of offender and addict; that is from the 16-year-old to the 35-year-old. You cannot pick a group. That is why it is so expensive.

The CHAIRMAN. I want to thank you very much. I know you are a few minutes late. I promise you we will call Congressman Rangel to tell him we kept you, and you are on your way, and we have you about three minutes late already. But thank you very, very much for coming down, Commissioner. I appreciate it.

Mr. COUGHLIN. Thank you.

[The following material was supplied for the record:]

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July 18, 1989

Honorable Joseph R. Biden
Chairman
United States Senate Judiciary Committee
Washington, DC 20510

Dear Senator Biden:

I appreciate your invitation to testify before the Senate Judiciary Committee on Tuesday, July 18 on boot camp corrections programs. I regret that I will be unable to appear at that time. However, I would like to describe my views in this letter.

As you know, I did a preliminary study of boot camp programs for the National Institute of Justice (NIJ) and wrote a report entitled Shock Incarceration: An Overview of Existing Programs. That report is now available from the National Criminal Justice Reference Service (1-800-851-3420). During the study, I observed six boot camp programs in four states (New York, Oklahoma, Georgia, and Mississippi), where I interviewed criminal justice officials, and boot camp administrators, staff, inmates and graduates. I also interviewed, by telephone, program officials in all other boot camp programs that were operating in late 1987.

I am enclosing for your consideration Chapter 3 of that report entitled "Advice to Policy Makers." The key points in that chapter are:

- It is too soon to tell whether boot camp programs deter or rehabilitate offenders any more effectively than other sanctions;

- Since boot camp programs are not a correctional practice of proven merit, any new program should be viewed as a pilot effort. As such, it should be designed as a test and operated with the primary goal of learning about the effects and consequences of this strategy. NIJ is currently sponsoring or coordinating evaluations in six states which should provide results in 18 months to two years. Until those results are available, new programs should be considered experiments that start out with rigorous evaluation plans.

- States should establish extraordinary administrative procedures to minimize the serious potential in boot camp programs for:

  -- inmate abuse
  -- inmate injury, and
  -- staff and departmental liability.

> State operated programs examined for the NIJ report often lacked strict standards in these areas. In contrast, the military boot camp model, now widely discussed (and under investigation by the D.C. Department of Corrections in collaboration with the Marine Corps) may benefit from the rigorous safeguards developed by the military to avoid abuse and injury during training. For more information about the standards for drill instructors and basic training, you may wish to speak to Admiral Peter Cressey, at 202-694-5217.

Much of the current interest in boot camps centers on two themes--first, that they are effective, and second, that they are cheap. As I noted above, we lack conclusive evidence, at this time, about their effectiveness. The best preliminary information suggests that return-to-prison rates are very similar for boot camp graduates and comparable offenders who got other sanctions.

With regard to costs, in every state we studied, boot camp programs cost at least as much to operate as regular prison living units with the same number of inmates. In states where boot camp programs emphasize rehabilitation--via remedial education, vocational training, counseling, and drug treatment--they cost considerably more to operate than regular prisons.

Advocates maintain that boot camps save money by confining inmates for shorter terms. Such savings occur only if most boot camp inmates clearly would serve regular prison terms if the program did exist. New York is the best example of a state in which boot camps shorten prison terms. In New York, Department of Correctional Services officials select boot camp inmates from among regular prison admissions. They know that each boot camp graduate will serve six months, rather than a longer term (typically 18-24 months) specified by New York's parole guidelines.

But in states where judges select boot camp participants at the time of sentencing, many practitioners believe a larger proportion of the boot camp inmates would have been placed on probation if the boot camp did not exist. If so, such offenders add to the prison population, prison crowding, and correctional costs.

Thus, if cutting costs is an objective, boot camp programs can be very effective, if they are properly structured. However, if they are improperly structured, they can increase prison populations, prison crowding, and correctional costs. If, as a matter of policy, boot camps were to be used as the sanction of choice for first offenders, they would substantially increase prison populations and total correctional costs.

In summary, there is no evidence to support large-scale expansion of boot camp programs at this point. We need more time to find out whether boot camps deter or rehabilitate, and whether they are cost-effective. If evaluation results are negative, the concept as currently implemented must be modified. If we find that boot camps deter or rehabilitate some types of offenders, we should develop new programs in a selective and rational manner, informed by the evaluation findings. At present, there is no basis for advocating boot camps as a "cure-all" for first offenders.

Thank you for the chance to present my views. If I can be of more assistance, please call on me.

Sincerely,

Dale Parent/cs

Dale Parent
Senior Analyst

DGP:cav

Chapter 3: ADVICE TO POLICY MAKERS

Correctional officials may reap short-term benefits by being identified with highly popular programs. However, when decisions to develop programs are made more on the basis of fad rather than hard facts about impact, the long-term costs may be high. If officials later discover that a highly-touted program has failed to meet expectations (or, worse, has been counterproductive), they lose credibility and their future program development efforts may be handicapped. As experience with Scared Straight has shown (see Appendix A), when public and political support for a program reaches a critical threshold, it becomes very difficult, if not impossible, to modify or abandon it—even if there is solid evidence that it does more harm than good.

Shock Incarceration has a strong appeal to criminal justice officials, politicians, and the public. The media conveys images of SI that appeal to gut-level desires to reek vengeance on criminals—even if the programs being portrayed are explicitly and primarily rehabilitation-oriented. In many states powerful criminal justice interests have coalesced quickly in support of SI, thereby seizing leadership on the content and timing of program development decisions. Unless correctional leaders are prepared to enter policy debates on SI at an early stage, they could lose their ability to influence outcomes.

The first question in policy debates is whether SI should be implemented or rejected. If the decision is to implement SI, other questions must be answered to refine SI purposes, configuration, and operation.

Deciding Whether or Not to Develop an SI Program

Correctional leaders should take an active role in policy debates on the potential promise and problems of shock incarceration. Close collaboration between correctional practitioners and researchers is especially important when policy decisions about new programs like shock incarceration are about to be made. By involving researchers early, practitioners can assure that policymakers' decisions are informed by the best and most current available research findings on SI and other relevant programs.

At present, we don't know enough about SI to make an unequivocal recommendation about whether states should or should not develop shock incarceration programs. We don't know whether SI changes offenders' attitudes, or whether it deters or rehabilitates more or less effectively than other institutional or community-based sentencing options. We don't know if SI is more effective for some offenders than for others. We don't know if some elements of SI programs are linked to participants' positive or negative outcomes.

The National Institute of Justice has recognized the need to inform future policy decisions, and has taken steps to encourage evaluation of SI programs. NIJ has funded a rigorous evaluation of the Louisiana IMPACT incarceration program. In addition, NIJ and researchers involved in the Louisiana program are working with officials in other SI states to develop a generalized evaluation design which will be implemented in at least five jurisdictions.

Clearly, if officials want to base their decisions to develop or reject SI on emerging empirical evidence about its impact and effectiveness, they should defer consideration of program development until preliminary evaluation findings begin to appear.

However, if political events force officials to make the "development/no development" decision before then, it is important that policy debates focus on the purposes to be served by shock incarceration. Officials should openly discuss goals and make a clear choice, or, if there are multiple goals, state a clear priority among them.

Officials also should define how those goals are to be achieved—that is, there should be a direct and plausible connection between what SI is supposed to do and key program components. For example, if rehabilitation is the primary goal, do officials expect it to be accomplished through changes in character or behavior caused by the disciplinary regimen, by exposure to traditional treatment modalities, or both? If rehabilitation is expected to occur via traditional treatment, what are the treatment needs of the offenders targeted for SI placement? Do appropriate treatment programs exist (or can they be developed) at the institution where SI will be operated? If reducing prison crowding is an important goal, what eligibility criteria and selection procedures will be used? Will they assure that most SI participants would have served regular prison terms if the program did not exist? If the selection process that is most politically acceptable in that jurisdiction likely will increase crowding, is it possible to develop support needed for a different selection process that will

be more effective in picking truly prison-bound offenders?

Advice for Officials Developing SI Programs

Again, we don't yet know enough about shock incarceration to make definitive recommendations about how programs should be designed. However, based on the experiences of the early SI programs, our interviews with correctional practitioners, and our direct observation of SI programs, it is clear that SI programs have a high potential for abusing or injuring inmates, and exposing state corrections departments (and possibly SI staff) to liability.

Therefore, for those proceeding to implement an SI program, we offer the following advice designed to protect inmates and staff, to limit potential liability, and to protect the legal and constitutional rights of persons in SI programs.

Inmate Protection:

- Inmates should have a complete medical examination and a licensed physician should certify them as fit for unrestricted participation before they are admitted to the program.
  - During this examination, inmates should be tested for diseases associated with intravenous drug use, such as endocarditis and hepatitis, that could pose a substantial risk for those required to perform strenuous physical exercise.
  - Persons should be excluded from SI who have AIDS or AIDS related complex (ARC). Persons who are seropositive to the HIV antibody, but who are asymptomatic, should be admitted, so long as a physician certifies that their current medical condition enables them to participate fully.
- Officials should develop clear policies governing physical training that gradually builds endurance while protecting inmates from dangerous physical stress levels.
  - States should use an authoritative physical training curriculum (such as that contained in the United States Army *Field Manuals* or contract with a qualified exercise physiologist or university physiology or physical education department to develop such a curriculum.
  - Such policies should:
    - Prohibit inmate participation in physical training until cleared to do so by a physician;
    - Strictly observe limits, if any, on participation in physical training set by medical staff;
    - Vary physical training requirements and intake of water according to weather conditions (e.g., in hot weather, exercise periods should be held during early morning and late evening hours);
    - Provide immediate medical attention for inmates who complain of headaches, dizziness, difficulty breathing, or other illness during exercise;
    - Refer for medical examination inmates who complain of an injury incurred during physical training; and,
    - Remove inmates from the program who are chronically unable to perform required physical training.
- Officials should establish an extraordinary and expedited grievance mechanism for SI programs, which would:
  - Provide a plainly marked, locked grievance box in an area openly accessible to inmates;
  - Forward materials left in the box unopened to an appropriate designated official – such as the Commissioner of Corrections, a state Ombudsman, or the Attorney General;
  - Require that official to conduct an immediate investigation; and,
  - Give SI inmates' unopened access to written comments sent to the judge who sentenced them and to their state legislators.

Staff Protection

- Officials should give a thorough medical examination to prospective staff who will participate in strenuous physical exercise, along with the inmates, and require a licensed physician to certify them as fit for such participation.

Limit State Liability

- Officials should require inmates to sign a form (bilingual, if necessary) stating they disclosed all known medical conditions or problems to prison medical staff when they were given admission physical examinations;
- Officials should require inmates to sign a (bilingual, if necessary) consent form volunteering to be in the program. The consent form should explain in clear language precisely what will be included in the SI program (physical exercise, strict discipline, work, etc.) and what the inmate's options are in terms of participation and subsequent withdrawal;

Legal and Constitutional Protection

- Officials should develop written policies governing conditions under which inmates may be expelled from the program and under which they may voluntarily terminate their participation. For expulsions, these policies should provide a level of due process equivalent to that used in hearings for disciplinary infractions that result (or could result) in a loss of good time.
- Officials should develop written disciplinary policies that distinguish infractions in the SI unit that will be:
  - handled by regular institutional disciplinary proceedings, and
  - subject to summary punishment in the SI unit.
- Officials should draft written policy that defines an exclusive list of sanctions that can be used as summary punishments and that sets clear, non-excessive, and absolute upper limits on the magnitude of such punishments.
- Officials should consider the legal ramifications of excluding older, physically handicapped, or physically impaired offenders from SI. Such offenders have a substantial liberty interest in access to a program like SI that could shorten their term of confinement. If older, handicapped, or physically impaired persons are not eligible for SI program, it may be necessary to give them other opportunities to shorten their terms of imprisonment;
- Officials should make SI programs available to both male and female inmates.

In the future, we may have evidence about SI's impact and effectiveness that enable us make definitive recommendations about SI program content. Until then, officials should make sure there is a direct link between program goals, program content, and methods of operation, so that there is at least a reasonable chance of attaining those goals. For example, if officials expect SI to change inmates' behavior by using program staff as positive role models, then policies that assure fairness and consistency in staff/inmates relations would be appropriate. Such policies might include:

- Training programs and guidelines for staff and supervisors that emphasize the importance of consistency in rule enforcement more than the harshness of punishments for rule violations; and,
- Written policies, staff training, and supervision, aimed at prohibiting SI staff and inmates from making derogatory comments based on persons' race, gender, or sexual orientation, including instituting practices that discourage sexual taunting of SI inmates by non-SI inmates.

If officials expect SI to rehabilitate offenders, in part, by means of traditional treatment, education, or vocational training programs, then policies should be developed which ensure that these programs will be delivered as intended (for example, policies that expedite approvals needed to fill staff vacancies). Finally, the policies should define a strong link between institutional and field services staff to assure continuity in provision treatment services and programs upon release.

The Critical Role of Evaluation

If officials decide to implement a new shock incarceration program, we strongly recommend that they make a firm commitment (including providing adequate resources) to conduct a rigorous evaluation of the program's effects and impacts.

Qualified researchers can help legislators and administrators determine whether a program's effects justify continued funding, and whether changes can be made to improve effectiveness. The earlier a researcher is asked to evaluate a program, the easier it will be to describe with confidence the components of the program that have been actually been implemented and to evaluate whether these components have resulted in positive or negative outcomes.

However, researchers also are bound by professional ethics to point out the limits of the programs most likely to reduce criminal behavior, and if supported by rigorous analysis, to advise the termination of even the most publicly popular programs. Therefore, before involving a researcher, officials should be sincere in their interest in knowing what effects the program has on participants. Officials must also be willing to cooperate in answering the following questions.

Who should design the program and on what basis?

Even skilled correctional officials may not alone have the expertise needed to predict what program elements will accomplish stated program goals. Just as experience in city driving is not sufficient expertise for highway design, experience in working with offenders does not by itself enable one to design a program that can reduce future criminal behavior.

People who have designed programs demonstrated to reduce recidivism among offenders typically have:

- a *proven* understanding of the multiple factors that increase the chance of an offender committing another crime, including individual and environmental characteristics;
- a *proven* understanding of the processes that lead an individual to refine his or her self concept and to reinterpret the meaning of his or her own actions and others behavior; and
- a commitment to building a program based on these understandings, rather than to proving a set theory or single approach [Chaiken, 1988].

Obviously, people with these characteristics are not limited to one profession. People who have designed effective programs include criminal justice officials, educators, psychologists, psychiatrists, sociologists, and ex-offenders with experiential knowledge. Frequently a team approach, with differing viewpoints polled prior to making final decisions on program design, may prove useful.

What are the goals of the program?

Correctional programs should be evaluated in terms of their intent. Some innovative correctional programs are designed to reduce recidivism. Others are designed to reduce overcrowding, to increase public safety, to cut costs, to impose greater discipline on inmates or staff, to provide income, or to increase offenders' self- esteem and self-control. Programs designed for reasons other than reducing recidivism should not be expected to have a positive effect on the future behavior of inmates.

It also is important to specify goals clearly in advance so that secondary positive or negative effects can be detected later by researchers. For example, it may turn out that stringent discipline increases, rather than reduces, recidivism for some types of offenders. Unless goals are defined in advance so that means of measuring them are incorporated in the evaluation design, it may be very difficult to say what caused particular outcomes or whether the same effects could be expected again.

Additionally, even programs with similar major goals may have differing sub-goals. Among programs aimed at reducing recidivism, for example, some address all criminality, while others are designed to reduce future involvement in specific types of criminal pursuits but not in others. Thus, a program designed specifically to reduce criminal behavior should not necessarily be expected to reduce technical parole violations.

As compared to inmates not involved in the program, specifically what activities are carried out by program participants?

Specific correctional programs often involve many more activities than those noted as integral. Sometimes, activities originally envisioned as integral never take place; sometimes they change in midstream. To determine whether or not a program was successful, it is necessary to know what activities are consistently carried out by program participants, and whether they are any different than those carried out by nonparticipants. Additionally, to replicate programs that appear to be effective, the activities must be well documented.

It is also necessary to determine how frequently program activities were carried out by participants. The numbers of times each day or week program participants carry out specific activities has been found to be a significant factor in changing subsequent behavior.

Who were the staff members involved in the program? As compared to staff supervising similar inmates in other programs, what is the ratio of staff to inmates, and what is their background and training?

Staff selection, training, and assignment can be just as or more important than the program activities in determining program outcomes. Staff who are neutral or hostile to the program's goals or planned activities can not elicit the same commitment from participants

as staff members who are themselves committed to the programs' goals. Committed but untrained staff members cannot be as effective as those who have received required professional and administrative training.

The ratio of committed and trained personnel to program participants is also a factor that needs to be considered in evaluation. Program effects may be linked to the formation of a trust relationship between the participants and at least one member of the program staff. If there are relatively too few staff members available, a relatively high failure rate may result.

Who are the participants and how are they selected?

Many programs appear to be successful just because they accept only participants who probably would not be recidivists even if they did not take part in the program. Other programs that actually have a significant effect on participants' behavior may appear to fail because they target high-rate dangerous chronic offenders who have an extremely high probability of being recidivists. If, for example, risk instruments predict that half the inmates in a shock incarceration program would return to prison within five years, a return rate of 30 percent could represent a major success. But if a program in another state recruited low-risk offenders, a 30 percent return rate could represent a major failure. In order to determine whether or not the program had a desired effect on participants' behavior, one must also ask, "In comparison to whom?"

The easiest way for researchers to answer this question is with a controlled experiment. Offenders that meet set criteria are offered placement in the program – but only half of the volunteers are randomly selected for participation. By comparing the subsequent behavior of the volunteers who participated with those who did not, it is possible to draw conclusions about whether changes in behavior were actually due to the program. Obviously, although controlled experiments are easiest for researchers they may be difficult for correctional administrators to implement; for example, programs may be under-enrolled and not have enough volunteers to randomly divide into participant and nonparticipant groups; staff members may be reluctant to reject someone who they think could profit from the program; or program providers may not want to accept someone they think will cause trouble. However, in many states the pool of offenders eligible for shock incarceration may be much larger than available program capacity. If so, correctional officials seriously should consider a controlled experiment, especially if they rather than judges control program admissions.

Because of the problems involved in controlled experiments, researchers often use comparison groups when evaluating correctional programs. They compare the behavior of program participants with the behavior of a group with similar characteristics; the more ways in which the comparison group is like the program participants, the more confidently the researcher can conclude that differences in behavior were due to the program. Characteristics especially important for comparison are age, sex, release status at time of last arrest (on bail, own recognizance, fugitive status for another crime) record of arrests and convictions for specific offenses – both juvenile and adult, vulnerability of victim, frequency and type of drug use, criminal record of other family members, prior record of employment, and community ties.

One method used in evaluating other types of programs is a comparison of the participants' behavior before and after they participated in the program. This is an acceptable method for evaluating programs designed to change compulsive behavior such as smoking or weight control. It may also be informative for studying programs targeted on specific forms of criminal behavior such as pedophilia.

However, before and after comparisons are *not* advisable to use for evaluating program effects on forms of behavior which in many cases ceases naturally.[1] Many forms of criminal behavior – even serious criminal behavior – are transitory and will cease with no formal correctional intervention. The vast majority of first time offenders do not become recidivists. The vast majority of adolescent offenders stop committing crimes when they approach their late teens or early twenties. Therefore, before and after comparisons are not recommended for evaluating the effects of most correctional programs.

Where does the program take place?

The environment in which a program operates can contribute to or detract from its potential success. The program's immediate environment can either foster or sabotage program goals. The peripheral presence of some individuals who are hostile to the program can

[1] Before and after comparisons can be useful in determining whether programs are achieving intermediate or internal objectives. For example, many shock incarceration programs expect that exposure to discipline and treatment programs will improve participants' self-image or change their attitudes toward authority between the time they begin and complete the program. Education programs offered in conjunction with shock incarceration have clear goals of improving educational levels. For such internal program components, a before and after comparison can provide valuable evidence about whether the program is working as intended.

actually enhance cohesion among participants by allowing for comparisons between "in-group" and "out-group" members [Chaiken, 1979; Turner and Killian, 1972]. However, it is very difficult to change participants' behavior if they spend a relatively high proportion of their time in contact with other offenders or correctional staff members who are hostile to the program. SI programs located at general population institutions typically separate participants from regular inmates. It is important to document the extent and quality of interaction between SI and general population inmates and to assess its effects on goal attainment.

Likewise, SI programs vary in the extent to which they promote esprit de corps among inmates. In a few programs the individual inmate is isolated and activities which might promote group cohesion (such as unison jodie calls, drilling competitions, etc.) are avoided. In others, platoons enter programs as a unit and stay together throughout the program. In addition to providing a focus for competition, the platoon becomes the core of a therapeutic community in the New York program.

Perhaps even more critical to a program's success is the environment surrounding participants after they are released from the program. In general, corrections programs that provide after care [Wexler, 1988] or 24 hour access to program staff [Chaiken, 1988], have a higher probability of success than programs that simply return offenders to the same environment in which they previously were committing crimes. As noted earlier, most shock incarceration programs provide more rigorous supervision for graduates, but not necessarily more intensive services or assistance.

How long are participants involved in the program?

There appears to be a minimum and a maximum time of program involvement that increases the probability of offender rehabilitation. Although these thresholds may vary, recent evidence suggests that periods of between nine months and one year of participation in a therapeutic program significantly increases the probability that attitudes and behavior will experience long lasting change [Wexler, 1988]. In light of such findings, it is important to ask if the current length of shock incarceration programs (3 to 6 months) is sufficient to affect participants' chances of success after release. This is a key question meriting further study.

What definition of "failure" should be used?

Various definitions of failure have been used in evaluations of correctional programs [See Table 3-1; Source: Maltz, 1984]. There is no single definition that should always be used. However, it is very important to use the same definition to compare the program participants with the comparison group. Practitioners and researchers need to decide collaboratively what definition of failure should be used. The definition should reflect program goals as accurately as possible. For example, a program intended to reduce violent behavior might define failure differently than a program with the more general goal of reducing "delinquency". However, when deciding what definition of failure to use, data collection costs must be balanced against the needed level of accuracy in measurements of programmatic goals.

In addition to collecting the official record information listed in Table 3-1, various methods for determining the behavior of participants and control group members after program completion include conducting interviews, carrying out surveys using written questionnaires, and more recently, urinalysis to provide data on drug abuse. These methods vary in the accurateness of the information collected and the cost of collection. Although no method produces absolutely accurate data, in general, the more accurately the data reflect the actual behavior of the individuals under study, the higher the costs are for collecting the data. For example, urinalysis data is more expensive to collect but more accurate than self-report data on use of drugs; and self-reports systematically collected by researchers are more costly to obtain, but more accurate, than information routinely collected by most probation and parole agencies or by police at arrest.

It also is important to remember that official record information reflects agency practice as much as it does the behavior of individual offenders. Therefore if the goal of the evaluation is to compare the relative success of programs being administered in two jurisdictions, the higher cost more accurate methods may be justified.

What measure of failure should be used to compare the program participants with the comparison group?

Until recent advances in evaluation research, the most common measure used for comparing program participants with a comparison group was the recidivism rate – the percentage of people in each group that failed during a set calendar period, usually a year. In the last few years, researchers at the forefront of developing methods for evaluation have strongly suggested that this measure is misleading, is biased, and throws away valuable information. [Maltz, 1984]. Use of this measure can actually mask significant effects programs have had on participants' subsequent behavior.

Table 3-1
Recidivism Definitions Used in Recent Studies

Definitions	Frequency
Offense data	
Recorded police contact	2
New offense	16
Severity of offense	16
Arrest	20
Parole-probation infractions	
Parole suspension	8
Parole revocation	8
Technical violation	26
Absconding	10
Probation violation	3
Court appearance	3
Reconviction	22
Sentencing	8
Return to prison	39

Source: Maltz, 1984, page 63

Two groups with fifty percent failures at the end of one year can have entirely different futures. If one group has almost all of its failures in the first three months and very few over the next nine months, we would expect it to have a better prognosis than one in which the failures have continued to mount throughout the year. In the first case, probably all who were going to fail have already done so, while in the second case the failing is probably not yet over. For this reason, an estimate of the *eventual probability of recidivism* is considered to be a better measure of a program.

The preferred measures are failure rates (the numbers of individuals who have failed at several progressively long intervals timed from their date of release) and survival rates (for individuals who have not failed, the amount of time after their release date they lasted without failure). Unlike the use of recidivism rates, which does not take into account the fact that different processes lead to recidivism at various stages after release, the use of failure rates and survival rates recognizes that there are critical periods after release and that the programs may foster the survival of participants at some specific stages but not others.

For example, some studies of corrections programs based on the Outward Bound model suggest that program effects diminish over time. If the effects of shock incarceration also are found to decline predictably over time, it may be important to consider ways to modify post-release supervision to re-stimulate initial positive effects.

What kinds of data are necessary for this measure?

Surprisingly, the data needed for this estimate are about the same as the data needed for analysis using a set calendar period. For each person who fails, the analysis requires the length of time between release and failure. For each person who has not failed (at least, during the period of observation), the analysis requires the length of time the individual was at risk, that is, the length of time between release and the last day she/he was observed. (Note that this method uses all of the time data, instead of just determining whether there was a failure before a certain date.)

What statistical method should be used to compare the failure measures for the program participants and the control group?

Researchers are continually improving statistical methods for analyzing the impact of correctional programs. Today s preferred method may be outdated by tomorrow. However, the method selected for analysis should be capable of:

- taking into account the characteristics of the program participants and people in the comparison group.
- taking into account the length of time individuals have been released and on the streets.
- utilizing all data on failure—and not throw away data on failure measures after a fixed calendar date.[2]
- utilizing all cases and not "throw away" individuals because they disappeared from a jurisdiction before a fixed calendar date.
- producing findings that are useful for making policy decisions.

Conclusion

Leaders in the corrections field have both a responsibility and an opportunity to shape new policy development to help reach key correctional goals. Administrators who are truly interested in finding out the effects of a correctional program on participants subsequent behavior need to involve a qualified researcher in their plans from the time the program is first under consideration. At the very least, an ongoing evaluation can demonstrate that program funds are being used for their intended purpose. More important, a rigorous evaluation can provide information needed to continually improve existing programs, justify the continued funding or expansion of effective programs, and identify programs whose results do not justify continuation.

The CHAIRMAN. Now I would like to ask Mr. Allen James, former heroin and cocaine addict and drug offender, and now the Director of Career Development at the Fortune Society, which is a private nonprofit organization in New York City that provides counseling and education services to ex-offenders and ex-addicts, and Mr. Bruce Wald, Director of the Key Program at Gander Hill Prison in Wilmington, Delaware, which is an in-prison therapeutic community of drug offenders, both to come forward.

Gentlemen, in the interest of time and opportunity to have an exchange here, I would appreciate it if you would try to keep your oral statements in the five-minute range, summarize them to that degree. We will put your entire written statements in the record as if read, and then we will move to questions. But I will wait until both of you have testified.

Mr. James, welcome. Thank you for the time and effort. Would you proceed, please?

STATEMENT OF ALLEN JAMES, EX-HEROIN AND COCAINE ADDICT, AND DIRECTOR OF CAREER DEVELOPMENT, FORTUNE SOCIETY, NEW YORK, NY; AND BRUCE WALD, DIRECTOR, KEY PROGRAM, GANDER HILL PRISON, WILMINGTON, DE

STATEMENT OF MR. JAMES

Mr. JAMES. Thank you, Senator.

As you stated—it is a great credential—I do have an 18-year background of intermittent drug abuse and criminal activity. I have been arrested a total of more than 16 times; I have been convicted of felonies on two separate occasions. I served time in a New York Correctional Institution once, a one- to three-year sentence. On the second felony conviction, I was given a jail sentence. It is a common practice in New York State to create a predicate felony situation in order to encourage the defendant to plead guilty to the felony, offer a sentence in a city jail of a year or less.

I did not begin drug abuse until I was almost 24 years old. I was about one year out of the armed services. I spent two years in the Army from 1965 to 1967. While I saw drug abuse and drug use throughout my tour of duty, it just never had any appeal to me at all. During the time that I was in high school and college before going into the service, I was exposed to lots of drug abuse, but it never had any appeal for me at that time, either.

The situation that set up when I was released from the Army was there was just widespread drug abuse throughout my neighborhood and throughout circles of friends that were outside my neighborhood, persons I knew in college, persons who had been friends of mine who were artists in parts of the city, and people outside New York City who I knew were also using drugs. I had noticed that people had moved on from use of marijuana and alcohol and occasional use of cocaine to using heroin.

I resisted it for quite a while, but in 1968, I began to inhale heroin, commonly called "snorting". The thing that I really did not realize was that I have no threshold for addictive substances of any kind. I was pretty quickly addicted—in fact, I was addicted before I even realized it. One doesn't realize that one is addicted to something until it is withheld.

At the point that I discovered the addiction, I began to struggle with it, and that struggle continued over that 18-year intermittent history.

My periods of remission from drug addiction almost always followed some catastrophic event, probably a period of incarceration. I recovered and was in remission at least three times—actually, those periods extended from six months to as long as four years. It is the relapse and remission cycle that probably is most interesting in my own case.

During times when my addiction was in remission, I never engaged in any criminal activity at all. I did achieve some things—I probably could be termed as having had three separate careers. At times when I was about to achieve beyond a certain level, on each of these occasions, I tended to relapse again. I tried things like psychotherapy, which did not work for me at that time. I had some drug abuse treatment, but not intensive drug abuse treatment. During the times that I was arrested and convicted, any time that I was incarcerated, I never had been offered any opportunity for treatment. The criminal justice system in general did not address that, even though on each of the times that I was arrested, it was clear that I was addicted, since I underwent withdrawal or went into a detox program in any correctional facility that I ever entered; the criminal justice system never took that into account.

In fact, it wasn't taken into account until 1985, when I had been arrested for a misappropriation of vehicle, possession of stolen property, a stolen automobile, and the judge looked at the pattern and said this person looks like a drug addict judging from the pattern of convictions—although the spaces in between were interesting to him. He had me questioned by my attorney and then offered the opportunity for me to seek residential treatment as an alternative to incarceration.

That situation was one where the maximum sentence that I would have received would have been 90 days. I had already served 60 days in detention. That meant in about 15 days, I could have been released free and clear. But I did opt to go into a treatment program, where I subsequently spent 18 months.

The first few months of the treatment program were relatively simple because I am a lot older than most of the people who were in the program at that time, and because I had had much wider experience than most of them, the first part of the experience was relatively simple. It was a matter of cleaning up, getting healthy and developing a better feeling about myself, to the point where I reached the stage of treatment where I was in a transitional stage back into the community, where I was working, where I still had to respond to the structures of my treatment program, but I was beginning to feel like I was like anyone else—at this place being a situation where I had to make a decision daily to remain in treatment and complete this process that I had begun.

I subsequently did complete the process. When I did complete it, I entered psychotherapy with a private therapist, and I continued with that for a year and a half. At the present time, while I don't regularly attend any structured type of therapy or treatment, I do maintain some ties with various groups, and I work in a business

that keeps me pretty much in touch with my own particular illness.

I'd like to end my background at that point, because I am quite anxious to get a chance to make comments on some of the other things that have been mentioned.

[Prepared statement of Mr. James follows:]

TESTIMONY FOR
SENATE JUDICIARY COMMITTEE HEARINGS ON
INCARCERATION AND ALTERNATIVE SANCTIONS FOR DRUG OFFENDERS
JULY 25, 1988 SESSION

Prepared by

Allen James
The Fortune Society
39 West 19th Street
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Allen James
July 25, 1989

Background Overview

I was born in September, 1945 and raised in New York City by parents who stressed the importance of education and personal excellence as a hedge against what they perceived to be broad based racism in this country. Both of my parents were musicians and my father traveled extensively in the United States and Europe. He was college educated and fairly sophisticated in his outlook. My mother worked in defense plants during World War II and was trained in electronics at a time when the technology was quite new. My mother stopped working in 1945 and stayed at home to care for me while my father supported the family, his work keeping him away from home for much of the year.

I was educated in parochial schools through the 7th grade and participated in special programs for gifted students when I entered the New York public school system. My parents were divorced when I was eight years old and I continued living with my mother in our Harlem apartment. She returned to work full-time but continued to supervise me closely at home. I saw my father frequently during the next five years but with no real regularity.

In 1962, when I was a high school senior, my mother became ill. Until that time I had maintained excellent grades in school primarily in response to extreme pressure from my mother to achieve. During the year that my mother was ill my grades began to slip. I failed classes for the first time and was generally undirected and without motivation. My mother died in the summer of 1962 and I went to live with an aunt in the Bronx, NY. I completed an extra semester in high school and graduated in 1963. In the fall of 1963, I entered Hampton University in Virginia on a full athletic scholorship for football and basketball. I did not return to Hampton in fall of 1964.

In 1964 I enrolled at City College of New York to major in English in the evenings and took a full-time job with Citibank, NY (then called First National City Bank). I failed to apply for a student deferment and was drafted in 1965. I enterd the army in November 1965 and served with the 218th Military Police Company in The Dominican Republic and the 503rd Military Police Batallion at Fort Bragg, NC.

I was discharged honorably from active duty in November 1967. I returned to my job and school in New York. I found that most of my friends were using drugs heavily. Many were already using heroin. I had used alcohol and marijuana as recreational drugs and experimented with cocaine but did not drink or use drugs regularly because it impaired my ability to function at work and in school.

I found, during early 1968, that my choice not to use drugs every day and my refusal to use heroin caused me to be alienated from my closest friends. I found that not only my neighborhood friends from childhood and teen years were using heroin, but friends from other circles as well.

I began inhaling heroin in mid-1968. By the summer of that year I was addicted. As soon as I discovered my addiction I began to struggle with it by attempting unaided withdrawal, by entering various detoxification programs and by buying illegal methadone on the streets in an effort to detox myself. I managed to maintain my job and outward appearance of normalcy but I was always in a state of extreme anxiety and disorientation. I was spending from $10 to $25 per day on drugs.

I was married in 1969 and still struggling with heroin addiction. I also used marijuana and alcohol and, occasionally, cocaine. At this point, I still used heroin and cocaine only by inhaling. I had never injected any drug.

My son was born in November of 1970. My addiction grew progressively worse and the expense was a greater burden because we now had a child. By the summer of 1971 I had begun injecting heroin and the addiction was too far out of control for me to hold a job or to keep up the appearance of normalcy. While injecting created a quicker, more intense high which, at first, lasted longer and reduced the amount of money that I had to spend daily, the effect soon reversed and I was spending more money than ever. During this period, my wife, family and in-laws tried to help me and support me in my efforts to shake off the addiction. But none of us really knew anything about the nature and dynamics of it. Out of shame and frustration, I left my family in summer of 1972.

With no particular place to go, I became immersed in the street drug culture. I learned that almost everyone in that culture committed crimes to support their drug habits. At that time, my habit cost between $20 and $40 per day.

During this period, credit cards began to proliferate. There were few controls on these instruments and computerization had not advanced to the point where swift cancellation of lost cards could be accomplished. I knew a good deal about banking procedures and financial instruments and I was able to support myself and my habit until the summer of 1972 by cashing checks and making credit card transactions with stolen cards.

During the summer of 1972 I became involved in drug dealing with friends whom I had known since teen years. During that summer there was a shortage of drugs on the streets and I was involved with one of the few groups able to acquire drugs in New York. Because of the panic, drugs were selling at a high price and the quality was generally low. The situation led to an increase in robberies of street level drug dealers. Our group had been robbed at gunpoint twice within a one month period. In response to the situation we began to carry weapons for protection.

In August, 1972 I was involved in a shooting incident which led to my arrest for attempted homicide, reckless endangerment and possession of a weapon. I spent ten months in detention awaiting trial. In June of 1973, after all charges except possession of the weapon had been dismissed, I was offered an opportunity to plead guilty to *attempted* possession of a weapon and receive a sentence of time served. The district attorney refused to cooperate with this offer and pressed for a prison sentence. Ultimately, I pled guilty to the attempted possession charge and was sentenced to 1 to 3 years in a New York State correctional facility.

At this point, I had never received any real drug abuse treatment and I still knew nothing of the nature of my addiction or of addictive/compulsive behavior. I served an additional fourteen months in maximum security state prisons. I was not offered any opportunity to participate in drug abuse treatment even though records showed that I was addicted at the time of my arrest. At that time there was only one specific provision for substance abusers in the New York State Penal Code. That provision, the Rockefeller Law was largely ineffective in that it served to tag and track drug abusers and provide legal means to return them to prison for lengthy sentences more than it attempted to treat addiction.

On my release from Auburn Correctional Facility in the fall of 1974, I went to live in Colorado at the invitation of a friend. While in Colorado, I attended college, working part-time as a counselor and full-time as a Tester for IBM Corp.

Unable to convince my wife to move to Colorado with our son, I returned to New York City to be with my family in the winter of 1976. In that same year I went to work as a computer service technician in New York and studied acting and film and theater production.

In 1978 I relapsed into heroin use and was addicted within a short time. I left my family again and, after losing my job, I resorted to petty crimes such as shoplifting when I could not secure stolen checks and credit cards. The price of heroin had doubled since my last active addiction and I quickly found the cost of my habit rising to around $100 per day. I had between 5 and 7 misdemeanor arrests during this period and 3 or 4 convictions.

In late 1978, I was arrested for the burglary of an insurance office in Pelham, NY. I was convicted of burglary and given a local jail sentence of one year. I was now a predicate felon with two felony convictions.

While serving the year in Westchester County Penitentiary, I met the director of a community theater based in White Plains, NY. While in prison, I wrote scripts for projects for the theater and was offered a job when I was released. I worked for the theater for two years and performed with companies in New York City between 1979 and 1981. I taught theater and creative writing classes in public schools and conducted seminars at colleges. I also completed two non-fiction books that were subsequently published in the United States and Europe. In 1981, I relapsed into drug abuse again and abandoned my career to return to the streets.

I avoided any further felony convictions but was arrested at least six or seven times and convicted of at least five additional misdemeanors over the next two years. After serving a short sentence in a New York City jail in 1983, I went to work for a health care center in New York as Director of Communications and Audio Visual Services. I worked for that institution for the next year and a half.

I suffered a third drug abuse relapse in 1985. When I was arrested for the last time in July of 1985, the cost of my habit had soared to a $200 per day minimum. I was using cocaine with heroin almost all the time and I often spent in excess of $500 per day. I supported my habit at first by credit card fraud and later through car theft.

As a result of my last arrest, for car theft, I served approximately 45 days in pre-trial detention. While in detention, I contacted several drug abuse rehabilitation programs to be considered for admission and to ask that they appear and inform the court of their willingness to accept me into treatment. Project Return Foundation, Inc. of New York City responded and sent a representative to appear in court. The judge offered me a choice of a sentence of 90 days in jail or a sentence of one year on probation with the stipulation that I complete drug treatment at Project Return. Since I had already served 45 days, this meant that I could have been out of jail with no legal encumbrances in about 15 days. My decision to plead guilty , accept one year probation and enter the drug treatment program was based on my realization of the fact that even if I got out of jail that day, I would only return to the life-style I had just left. I had no idea of how to break the pattern of relapse into drugs and crime that had persisted over so many years. My decision was to ask for help in doing something I had given up any hope of doing alone.

I entered Project Return in August 1985 and remained in treatment there for 18 months. During the last six months of my treatment, I was employed by that agency as Assistant to a Program Director.

In June of 1987 I went to work for The Fortune Society, in New York, an organization that provides services to approximately 1500 ex-offenders each year. I started at Fortune as a Job Developer, locating and developing employment opportunities for ex-offenders and recovering substance abusers. I was later promoted to Director of Fortune's Career Development Unit. I am currently working for that agency as Director of Career Development and Adult Counseling.

In my case, there is a clear pattern of achievement - relapse - criminal activity - - incarceration - achievement - relapse. Even though I struggled with the problem on my own over the years, even entering psychotherapy in 1979, I was unable to break it because I didn't see myself as suffering from a clinical disability. Narcotics Anonymous and Alcoholics Anonymous refer to addiction as *disease*. Many pathologists agree that the behavior can be so termed. I was constantly puzzled by my own behavior. I could never understand how I found myself addicted after many drug-free months and how I could destroy everything that I worked so hard to build. The pain and damage that I caused to the people who cared for me contributed to a tremendous sense of guilt. I later learned that unresolved feelings of guilt are an important trigger mechanism for me. I never matched the patterns of my emotional states to the patterns of my drug abuse relapses until I was helped to do so during my treatment. Until I learned the importance of recognizing my emotional condition, I had never really been in touch with my feelings. In fact, I had been trained from childhood not to show emotions. Consequently, I almost always denied any feelings that I thought were weak or unattractive.

My experience at Project Return included the discovery of my patterns, weakness and emotional triggers. It also included 18 months of learning to make difficult decisions and to avoid shortcuts.

The recovery process is a long and complex one. However, it is sometimes useful to oversimplify the problem at a certain point in recovery. I have distilled it for myself to this: I will constantly experience emotional peaks and valleys throughout my life. In the past I have been unwilling to endure the valleys and the unpleasant feelings associated with them. For many years, whenever I have felt less than terrific, I have taken something to feel better. I have not been and will never be able to control the substances that I have taken to feel better. If I persevere in doing the things that I know I must, I will move through the valleys and on toward the next peak. I will feel better. I cannot take anything to feel better.

Assessments and Recommendations

Relevant Background and Characteristic Factors In Addicts

During eighteen (18) years of intermittent drug abuse, I have had no fewer than sixteen (16) arrests and at least eight (8) convictions, two of them felonies. I have undergone more than eighteen (18) months of intensive residential treatment and a year and a half of psychotherapy . I have also worked as a counselor, vocational counselor and administrator with substance abusers and ex-offenders for more than four years. I have known many other people who were addicted to drugs and still are. I continue to meet and work with such people every day in my present job. I have observed that there are several commonalities in the backgrounds and profiles of many addicts. Some of these are: experience of emotional trauma stemming from unstable family life during childhood or from family upheaval causing instability; childhood experience of physical, mental and/or sexual abuse; poor preparation for independent coping; lack of foundation in confronting emotional distress through communication with concerned others; deficits in decision making abilities; inability to defer gratification.

Addiction and Criminal Behavior

A large number of offenders begin their criminal behavior only after introduction to drug abuse and subsequent addiction. During periods of remission of the addiction, criminal activity tends to decrease or stop. Ability to delay or prevent relapse is often directly dependent on the availability of support mechanisms, resources and ability to acquire productive employment.

The Criminal Justice System

My experience with the criminal justice system, first as an offender and now as a professional, is confined primarily to New York State. Therefore my firsthand observations are limited to New York.

At a time when every level of the criminal justice system is operating under extreme pressure of the numbers of people and cases that it must handle, much of its activity is calculated to help to keep it from being swamped and brought to a standstill by sheer volume. As a result, the primary imperative is often to move cases through the system rather than to carefully examine each one and make decisions for the greater good of the community. Longer sentences are often seen as the solution because they get the offender off the streets. In addition to the cost factors associated with this "solution", it must be considered that longer sentences do greater damage to the offender's ability to ever make a successful transition back into the community when he eventually is released. The system is political in its nature and it reacts to the public's growing fear and outrage and demand that something be done. Reactive solutions have always failed to take into account the fact that almost all of the persons who are incarcerated will eventually return to the community. Addicted offenders usually return to the community without having received any formal treatment for their addictions. In spite of their willingness to lead productive lives, they are at tremendous risk of relapse and recidivism. Innovative solutions which take a longer term view and address the underlying issues that perpetuate the cycle are needed at this point.

Statistics compiled by The Fortune Society for 1988 indicate that 72% of all of its ex-offender clients report some substance abuse background. We believe that the client population of The Fortune Society can be seen as representative of New York's and the nation's ex-offender population. The United States Department of Justice Bureau of Justice Statistics recently published a report on offenders released from prisons in eleven (11) states, including New York. The report cites a recidivism rate of 62.5% within three years of release from prison. We can infer that a large percentage of these recidivists are drug abusers. Therefore it is clear that a well thought out initiative must be undertaken to address substance abuse. A window of opportunity for intervention opens at the point of arrest.

Drug Abuse Treatment

Some common goals of drug abuse treatment may be seen as the following: to make the abuser aware of his or her own behavior, both as a pattern and as a series of individual day-to-day decisions and actions; to help the abuser to become aware of consequences of any behavior; to help the abuser to discover how emotional condition impacts on decision making and actions; to help the abuser to recognize and identify emotions (be in-touch with feelings); to provide an environment in which the abuser can interact with peers under structure and supervision and receive constant feedback on behavior, both positive and negative; to help the abuser to establish or re-establish positive values; to help the abuser

to learn to set and pursue goals and objectives and to acquire decision making skills; to provide positive role models for the abuser; to provide the abuser with a structure and base from which to make a smooth, supported transition into a positive and productive life in the greater community. The treatment environment needs to be staffed by competent clinical and support professionals, some of whom might be recovered abusers.

Prisons, characteristically, do not provide the environment or the services where a drug abuser is likely to receive any of the above. Social values in prisons are largely negative; offenders convicted of the most serious crimes often occupy the upper portion of the inmate social hierarchy. Social mechanisms are skewed to make violence an acceptable method of conflict resolution. An inmate who attempts to confront his troubling emotions or to explore some early emotional experience through talk or show of such emotions in the prison culture is viewed as weak and is likely to become extremely vulnerable. Pursuit of higher positive values is not encouraged in the prison culture and behavior change is accomplished by negative reinforcement. Prisons tend to provide opposites to the principles of addiction treatment and rehabilitation. The culture reinforces the underlying causes of addictive behavior and, by extension, increases risk of relapse and recidivism upon release.

Drug Abuse Treatment Instead of Prison

In cases of first offenders and petty offenders with drug abuse backgrounds, serious consideration should be given to finding alternatives to incarceration. If we view the arrest and detention as the opening of a window of opportunity for intervention into a developing cycle of destructive behavior, it is clear that such alternatives should be centered around intensive treatment. With regard to persons addicted to heroin and/or *any form* of cocaine, long-term residential treatment should be considered because it is usually necessary for the abuser to remove from the environment and associates frequented during addiction. In addition, environment is a critical factor when attempting to alter human behavior.

The effectiveness of drug abuse treatment of any length, no matter what modalities are employed, cannot be easily predicted. Success or failure must depend on the eventual sequence of many events as much as on the character, motivation and disposition of the subject.

While relapse often does occur after completion of a structured treatment program or during that treatment, what a drug abuser learns during the treatment experience will increase the chance that he or she will be able to recover from the relapse, because much groundwork will have been laid. It must be remembered that in many cases, we are attempting to reverse behaviors that have been in place for many years. And we are attempting to do this in just a few months. We must be willing see the first treatment experience of any substance abuser as one part of the overall recovery process which may include one or more relapses.

Treatment In Prisons

One of the most practical methods of implementing drug abuse treatment in prisons is to create an institution within an institution. This method is currently in use in several New York State correctional facilities. It is the establishment of a *drug-free therapeutic community* within the institution with screened participants and correctional staff. A full staff of therapeutic counselors and support personnel are also employed. Within the therapeutic community, inmates respond to a separate structure of rules and participate in group and individual therapy sessions while establishing an environment in which each participant receives and provides feedback on behavior in a peer interactive process.

Some of the clients that I meet at The Fortune Society have experienced programs such as this in the prison setting. Many of them demonstrate a clear and in-depth knowledge of the nature of addiction and of their own addictive behaviors. A good percentage of them begin acting on this knowledge after release from confinement by seeking the ongoing treatment and counseling which are necessary for them to transfer what they have learned from the confined community to the greater community. This continued treatment is key because the experience of treatment in a therapeutic community inside a prison does not include the critical factor of volition. The fact that a person in a treatment program is there voluntarily and is able to leave at any time provides an opportunity to make a daily decision to remain in treatment. Repeatedly making this decision strengthens the will and determination of the person to struggle toward a goal. The treatment environment is deliberately made uncomfortable and strewn with obstacles placed there to encourage development of coping skills. Recovering drug abusers benefit tremendously from voluntarily enduring in a difficult treatment process which they can leave at any time but which they choose ultimately not to leave until completion.

Narcotics Anonymous (NA) also offers to enter many correctional institutions to conduct meetings at which addicted persons can begin to confront the nature of their condition from a new and useful perspective. NA is a twelve-step program utilizing the same principles as Alcoholics Anonymous (AA). AA is perhaps the most widely recognized treatment option for alcoholics seeking recovery. One of the most important and effective aspects of the twelve-step program is the establishment of a mutually supportive network of persons at varying stages of recovery. The nation-wide network of groups publishes schedules of meetings which happen 7-days a week, 24-hours a day.

Inviting NA and AA into institutions can provide means of treatment where none exists or in conjunction with some other institutional initiative, and the costs are minimal.

Transitional Resources and Services

However innovative and intensive treatment services within the prison may be, the risk of relapse within a short time after release is great. The change in environment and disillusionment on confrontation with new realities in the greater community trigger powerful emotional processes. Recovering addicts returning to the community from prisons need support mechanisms, i.e., family support; positive social network; opportunities for employment; counseling; therapy and formal drug abuse treatment. Lack of any one or combination of these can lead to relapse and recidivism in a fairly short time.

Because addiction is characteristically progressive, each relapse is likely to progress more rapidly, leading to criminal activity sooner than in previous relapses. The use of drugs is likely to become heavier sooner and the criminal activity may become more serious. Therefore it is in the interest of the community as well as the drug abuser to intervene with treatment at the first opportunity.

Any treatment provided in prisons must be followed up with intensive treatment after release. Resources for housing, emergency financial assistance, employment, and counseling must be provided. Opportunities for socialization and educational services must be available.

These are the things that our clients need and ask for when they arrive at our doors at The Fortune Society. We offer some of these services ourselves and make referrals to other agencies and providers for those we don't offer. Housing, financial assistance and residential drug abuse treatment are the most difficult services to find. Since we cannot provide them ourselves, we are constantly seeking resources in these areas. The resources

are shrinking in a time of increasing need. Often the substantial personal progress that our clients have made in recovering from addiction and criminal behavior while in prison is undone when they find themselves confronted with a bleak array of options for housing, employment and socialization.

The vast majority of our clients with drug abuse backgrounds have yet to receive meaningful treatment and have no understanding of why they repeat the same destructive behavior time after time.

Recap of Recommendations

Alternatives to incarceration involving drug treatment for offending drug addicts should be considered more often.

A greater initiative should be undertaken to place recognized drug treatment modalities inside correctional institutions so that they can be available to any inmate wishing to take advantage of them.

Incarceration without opportunities for offenders to receive high quality treatment is doing nothing to reverse the dynamic presently operating in our communities. If anything, it is feeding it.

Funding should be made available for, at the very least, quadrupling existing numbers of beds in residential drug treatment programs. Close attention should be given to maintaining high quality of treatment standards for rehabilitation programs. This should be done with expectation of a hign percentage of relapses within the first year.

The relative effectiveness of drug abuse treatment should not be measured simply by the number of relapses. It should be measured against the magnitude of the problem and the ineffectiveness of our present methods of coping with it.

A substantial number of those who relapse during or after treatment will recover. It must be remembered that this is a problem that we have allowed to persist into a second generation and grow by the laws of its own geometry. Our expectations should be reasonable within this context.

Innovative and well thought out programs to offer transitional services for persons released from prison should be funded with specific attention to housing, emergency financial assistance, employment and education.

Finally, it must be remembered that while this problem has grown, over time, in volume, it has also grown in complexity and we must expect that we will discover many of the solutions only after we have begun to devote serious attention and resources to it.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	CLIENT INFORMATION - FISCAL YEAR 1988/89															
2	ADULTS	1988	1988	1988	1988	1988	1988	1989	1989	1989	1989	1989	1989			
3		JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL *	%	
4	FEMALE	16	14	7	11	15	13							76	14	(6 MONTH
5	MALE	80	79	75	84	65	76							459	86	(6 MONTH
6																
7	DRUG ABUSE HISTORY	72	56	63	68	66	61	72	45	68	70	78	73	795	72	
8																
9	HISPANIC	32	22	17	26	24	19							140	26	(6 MONTH
10	BLACK	54	64	54	57	45	61							336	63	(6 MONTH
11	WHITE	10	6	11	11	10	7							55	10	(6 MONTH
12	OTHER	0	1	0	1	0	2							4	1	(6 MONTH
13																
14	PROBATION	17	16	11	14	14	18	19	15	6	10	20	14	176	16	
15	PAROLE	41	27	30	35	25	22	32	36	36	52	42	45	426	39	
16	WORK RELEASE	10	11	2	7	6	7	10	5	5	6	4	4	77	7	
17	OPEN CT CASE	9	5	5	4	6	11	14	3	11	2	14	6	90	8	
18	OTHER	19	34	34	33	29	31	30	19	29	27	20	23	330	30	
19																
20	NO INCOME	82	64	57	56	46	46							355	66	(6 MONTH
21	EMPLOYED	2	3	1	8	5	6							25	5	(6 MONTH
22	UNEMPLOYMENT	0	1	1	2	2	0							6	1	(6 MONTH
23	PUBLIC ASST	12	25	22	26	26	33							144	27	(6 MONTH
24	SS/SSI	0	0	1	0	0	2							3	1	(6 MONTH
25	OTHER	0	0	0	1	1	0							2	0	(6 MONTH
26																
27	TOTAL NEW ADULTS	96	93	82	95	80	89	105	78	89	97	100	95	1099	100	
28																
29	OUTREACH ACTIVITIES	6	2	1	1	4	4	0	3	4	4	6	3	38		
30																
31	PLACED - TREATMENT	2	1	2	2	1	2	3	5	2	2	4	2	26	2	
32	PLACED - RECOVER	1	2	0	1	2	1	4	1	0	1	5	3	21	2	
33	PLACED - ARRIVE										1		11	12	1	
34	COMPLETED ARRIVE											1		1	0	
35																
36	ATTENDED CD WKSP	37	41	28	15	15	27	34	22	18	21	30	30	318	29	
37	COMPLETED WKSP	25	26	17	10	10	12	15	14	9	18	22	19	199	63	
38	TOTAL CLIENT CD MTGS	117	125	79	40	36	52	64	49	41	60	119		781		
39	JOB PLACEMENTS	13	21	10	5	15	11	11	5	5	3	10	8	115	58	
40	TRAINING PLACEMENTS	3	0	7	3	4	0	2	1	1	1	6	7	43	22	

Statistics are incomplete for January '89 - June '89 as The Fortune Society is in the process of compiling data for a mid-year report. (aj)

The CHAIRMAN. You said you could say you had three separate careers. What were those careers?

Mr. JAMES. Well, my first career was in banking, which was kind of promising, in the Sixties. I returned to that when I got out of the military, and I left it as a result of my first experience with addiction.

After having worked at the University of Colorado in Boulder, I came back to New York and worked as a customer engineer in computer technology, and suffered a relapse. After that, I worked for approximately six years as an actor, writer and teacher. I experienced quite a bit of success in that field, and I am presently working as an administrator in the nonprofit sector.

The CHAIRMAN. Thank you.

Welcome, Bruce. It is good to see you down here. Would you please proceed?

STATEMENT OF MR. WALD

Mr. WALD. Thank you, Senator.

As an opening statement, I'd like to talk about something that you alluded to much earlier, and I'd like to read a few pages, and then we can go on from there.

The correlation between substance abuse and crime has long been established and accepted in many quarters. In fact, studies indicate that inmates with a history of substance abuse have a proportionately high rate of recidivism. The Federal Government has and is expanding procedures and attempts to quell the illegal importation of these substances.

State and city law enforcement confiscate large quantities and arrest both users and sellers. The judiciary seems to mete out longer and harsher sentences. The legislative bodies pass stringent laws and allocate moneys for the expansion of housing for inmates in the correctional system. Various techniques of mental health and criminal justice have been tried, and in the majority of cases, most of the people relapse and have returned to criminal activity.

Criminal sanctions alone do not significantly reduce criminality or drug use, but may provide the setting for treatment. Evidence from the research literature indicates that some specialized treatments are successful in reducing recidivism.

Crime and drugs are so intertwined that they cannot be extricated from one another. Those involved in predatory crimes—robbery, muggings—commit six to eight times more crimes during their active drug use. More defendants are being arrested on drug charges than any other category. Unless we intervene, they will continue to commit crimes, and prison populations will continue to grow.

The quality of life is decaying consistent with the amount of drug use we see simply because drug use and crime go hand-in-hand.

Dr. James Inciardi, Director of Criminal Justice at the University of Delaware and an eminent researcher, states, and I quote: "We have been plagued with a number of competing philosophies as to what prisons ought to be for." Should we isolate criminals? Should we punish criminals? Should we change criminals? Do we protect

society—combined with the fact that the general public feels that criminals should be warehoused, which is not the solution.

Over 95 percent come out again, and if you don't change them via treatment, they will pick up their asocial predatory behavior again.

Society feels that justice is served when a perpetrator is arrested and convicted but does not realize that at the same time, when that individual person is incarcerated, at that time, others who committed similar offenses are being released, having become more hateful, tougher and gained more knowledge about criminality, and the vicious cycle continues.

Chronic, hardcore users are arrested more often. They are responsible for a substantial amount of street crime. According to Dr. Bruce Johnson of Narcotic and Drug Research, Incorporated, heroin and cocaine users and offenders are responsible for 80 to 90 percent of all drug transactions, and they each commit approximately 10 to 20 robberies, 30 to 50 burglaries yearly, and numerous other offenses as well—they only comprise 3 percent of the prison population, but they are responsible for 60 percent of the robberies committed in this country.

Federal statistics show that there are approximately one million incarcerated individuals throughout the country. This includes prisons and jails. State and correctional systems are continually grappling with escalating budgets. Costs per inmate incarcerated in a prison or jail vary from $9,000 to $30,000 annually as opposed to treatment costs, which vary from $200 to $300 per inmate, depending upon the type of treatment.

The last segment I would like to talk about, and it was just mentioned, is AIDS and people who are HIV-positive.

As we must know, the main vector for spreading the AIDS disease among the heterosexual population is the IV drug user. In a recent research paper that Mr. Inciardi will be publishing out of a grant from the National Institute of Drug Abuse, adolescent females are exchange sex for crack, either by prostituting for money to purchase crack, or prostituting for the crack. Exchanges are almost as predominant as the monetary exchange. Through IV drug use or sexual interaction, there is imminent danger of both contracting and spreading AIDS. The average age is 15 years old, and I was told that there were some women interviewed in Miami who were as young as 10.

Recently, the Washington Post put out an article about infant mortality, and in Washington, D.C., the average is twice above the national. So when we are talking about drug abuse and indiscriminate sex which is tied with crime, we are talking about a major problem, and I believe that this needs to be addressed.

As to what we do in the KEY program, I am sure Senator Biden will ask me some pertinent questions.

Thank you.

[Prepared statement of Mr. Wald follows:]

COMPREHENSIVE TREATMENT FOR SUBSTANCE ABUSING INMATES IN A CORRECTIONAL SETTING

Bruce Wald, Director
The Key Program

POSITION STATEMENT

THE KEY PROGRAM

The correlation between substance abuse and crime has long been established and accepted in many quarters. In fact, studies indicated that inmates with a history of substance abuse have a proportionately high rate of recidivism. The federal government has and is expanding procedures in attempts to quell the illegal importation of these substances. State and city law enforcements confiscate large quantities and arrest both users and sellers. The judiciary seems to mete out longer and harsher sentences. The legislative bodies pass stringent laws and allocate monies for the expansion of housing for inmates in the correctional system. Various techniques of mental health and criminal justice have been tried and, in the majority of cases, most of the people relapse and have returned to criminal activity.

Criminal justice sanctions alone do not significantly reduce criminality or drug use but may provide the setting for treatment. Evidence from the research literature indicates that some specialized treatment programs have successful in reducing recidivism. The Key Program is based on the social learning theory principle that criminal behavior is learned through a process of social interactions and that prosocial actions must be learned to replace the deviant ones. In the late 1950's, a revolution in philosophy and practice came about in the treatment of substance abusers via the Synanon Program in California. Faithful adherents of that philosophy initiated programs on the East Coast such as Daytop Village and Phoenix House. Their statistical rates of recovery and positive productive lifestyles solicited the attention and praise of both mental health and criminal justice professionals alike.

Over a decade ago, a new program called Stay 'N Out began using this philosophy and treatment in the correctional systems in New York State. Research statistics have shown the program to be effective in quelling recidivism and the use of mind and mood altering chemicals. Because of the proven effectiveness of this program, some states have developed or are in the process of developing prison-based therapeutic communities.

In July of 1988, The Key Program a therapeutic community, was instituted in the Multi-Purpose Criminal Justice Facility, located in Wilmington, Delaware, in cooperation with the Department of Correction and the Bureau of Justice Assistance. After a number of expert evaluations, The Key Program was deemed to be well on its way, and considered a model for other programs around the country.

Crime and drugs are so intertwined that they cannot be extricated from one another. Those involved inpredatory crimes (robbery, muggings) commit 6-8 times more crime during their active drug use. More defendants are being arrested on drug charges than any other category. Unless we intervene they will continue to commit crimes, and prison populations will continue to grow. The quality of life is decaying consistent with the amount of drug use we see. Simply because drug use and crime go hand-in-hand.

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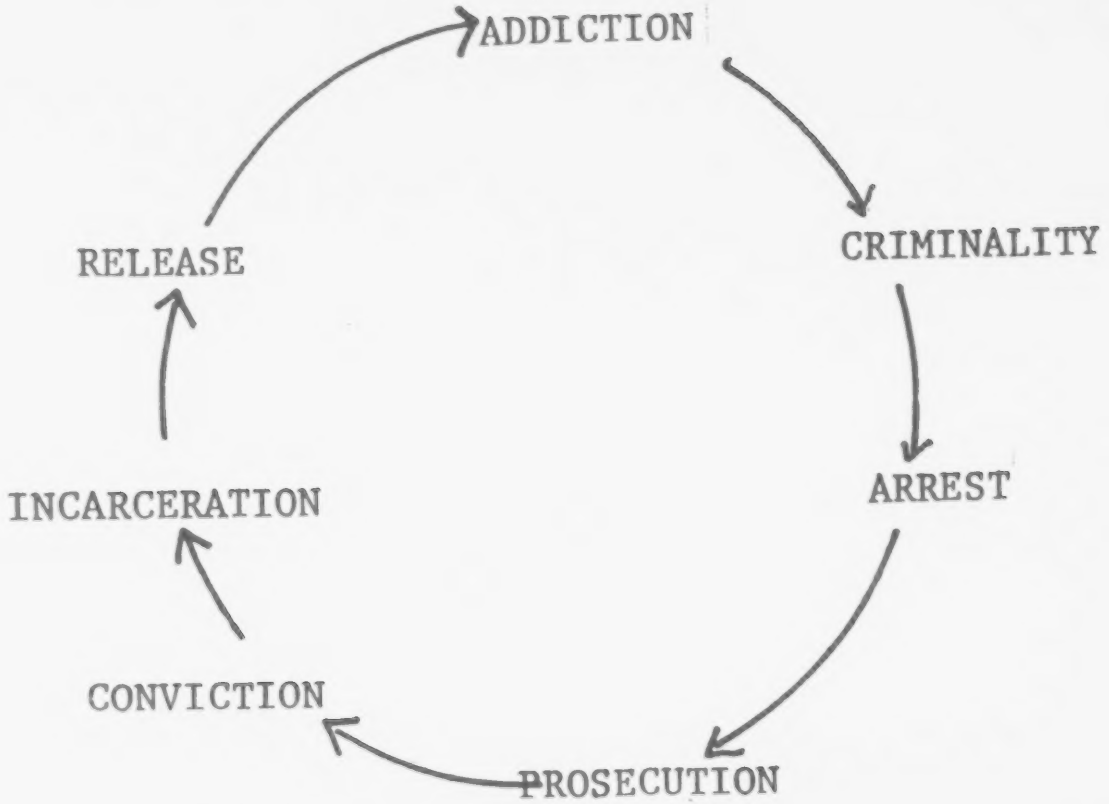
Federal statistics show that there are approximately 1 million incarcerated individuals throughout the country. State and correctional systems are continually grappling with escalating budgets. Costs per inmate incarcerated in a prison or jail vary from 9,000 to 30,000 annually, As opposed to treatment costs varying from 200 to 3,000 per inmate depending upon the type of treatment.

CRIMINAL USER CYCLE



Significance Of The Project

A survey of 12,000 state prisoners nationwide conducted by The Bureau of Justice Statistics (1983) revealed that 75% (9,000) of the prisoners surveyed had used drugs at some time in their life. 56% (6,720) of the prisoners had used drugs within 30 days of the arrest leading to their current incarceration. Finally, approximately 33% (3,960) were using drugs at the time of the crime leading to their current incarceration. The rates of drug use among prisoners are also higher than those in the general population. Prisoners are twice as likely to have used drugs and three times as likely to have used within the last 30 days than individuals in the general population. There appears to be a relationship between drug abuse and criminal activity. If this is the case, then treatment for substance abuse should have an impact on criminal activity.

Selection of the Therapeutic Community Model

The therapeutic community model was selected because it has been identified as the most effective modality with substance abusers (DeLeon, Holland, and Rosenthal, 1972; Simpson, 1979, 1980). Findings from community-based therapeutic communities show that successful outcomes are related to at least two major factors. First, reductions in crime and substance abuse, and increased employment are positively related to time-in-treatment. Second, greater success was achieved with clients referred by the courts with clear sanctions for program noncompliance. This latter factor is significant because of the high drop out rates that are observed within the first three months following admission to the therapeutic community.

Both of these findings were used as rationals for the development of a prison-based therapeutic community. The therapeutic community is an attractive alternative for inmates to life in the general population of the prison for several reasons. First, the treatment unit is isolated from the general population, a situation which can create both physical and psychological safety. Second, the clinical staff are ex-offenders and/or recovering addicts. This creates a situation in which the clients can more easily identify with the staff than might otherwise be possible. Third, individuals in treatment are offered a variety of incentives for their participation. These include assistance in preparing for parole board appearances, opportunities for better jobs in the prison, and help in networking with community-based treatment services upon release. Fourth, the therapeutic community is an ideal treatment model for use in the prison setting because clients are likely to stay beyond the three month drop-out point because of its desirability aspects.

Wexler, Lipton and Foster (1988) conducted a study to examine the effectiveness of a prison-based therapeutic community (Stay 'N Out), Arthur Kill Correctional Facility, Staten Island, New York). The following comparison groups were studied: 1) , therapeutic community participants; 2) therapeutic community candidates who were never admitted (for treatment reasons); 3) prisoners in other substance abuse treatment programs; and 4) prisoners receiving no treatment. The outcome variables for males and females included positive parole discharge, time to first arrest, and total number of arrests. The researched hypothesized that: 1) outcomes on parole would be positively related to level of treatment intensity (tc, counseling, no treatment); and 2) time-in-treatment would be positively related to outcomes for the therapeutic community participants. No predictions for time-in-treatment were made for the counseling or no treatment groups.

Males and females from the therapeutic community had significantly lower arrest rates than those in all other forms of treatment or non-treatment (see Table 1). In addition, time in treatment for therapeutic community males related positively to time to first arrest (see Figure 1). Further, 9 to 12 months in therapeutic community appears to yield the most positive parole discharge <u>impact</u> for females in the therapeutic community (see Figures 2 & 3).

The Key Program is a therapeutic community for substance abusers housed in a correctional institution.

The Program presents a positive family environment, where residents live and work together, developing a sense of responsibility, caring and cohesiveness.

Our staff represent the "Parents" or "Authority Figures" with a chain of command that must be followed in a no-nonsense, but nurturing setting.

Residents move up the ladder by following the rules, presenting positive attitudes, participating in all program and group activities, including the willingness to do their best in all assigned job functions. In turn, but being more responsible, they earn more privileges and status in the community.

In developing criteria and interviewing procedures, The Key Program followed these assumptions: 1) perspective resident should have a history of cronic substance abuse; 2) in most cases the inmate should be a multiple offender (that's a person who gets out and cannot stay out) going through the cycle of addiction crime and incarceration; and 3) and after interviewing, had some realization that they have been living in a non win situation and needed to change.

Table 1

Parole Outcome Arrest

Males	Total N	% Arrested
TC Treatment	434	27.0
Milieu Treatment	573	34.6
Counseling Treatment	260	40.0
Young Treatment	205	53.7
No-Treatment	155	40.5
Chi Square		44.55
Probability		.0001
Females		
TC Treatment	246	17.9
Counseling Treatment	113	29.2
No-Treatment	38	23.7
Chi Square		5.95
Probability		.05

From Harry K. Wexler, Ph.D., Douglas S. Lipton, Ph.D., and Kenneth Foster, "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment Preliminary Results," paper presented at the American Society of Criminology, San Diego, California, November, 1985, page 11.

Figure 1

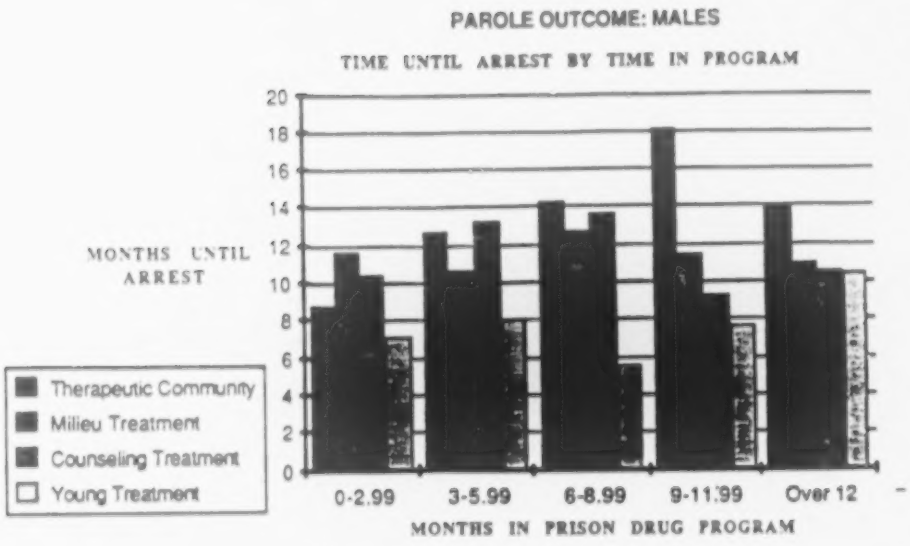


Figure 2

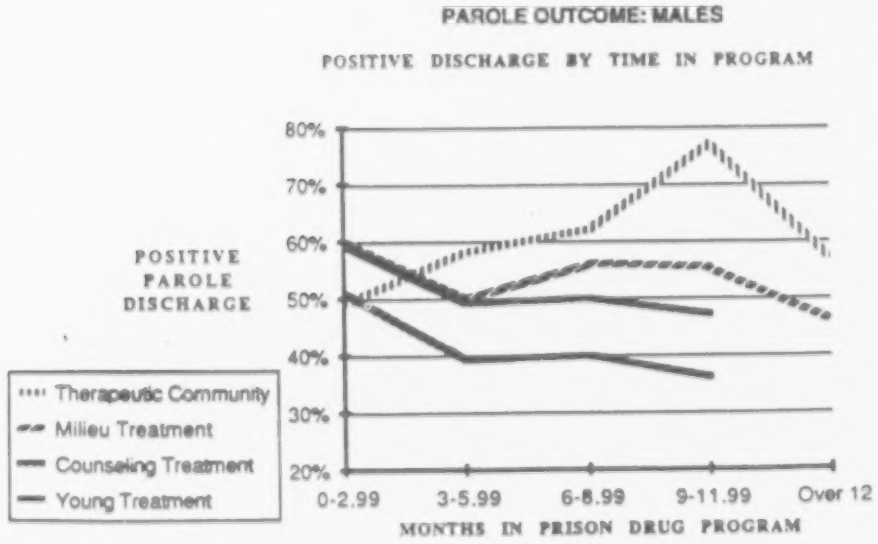
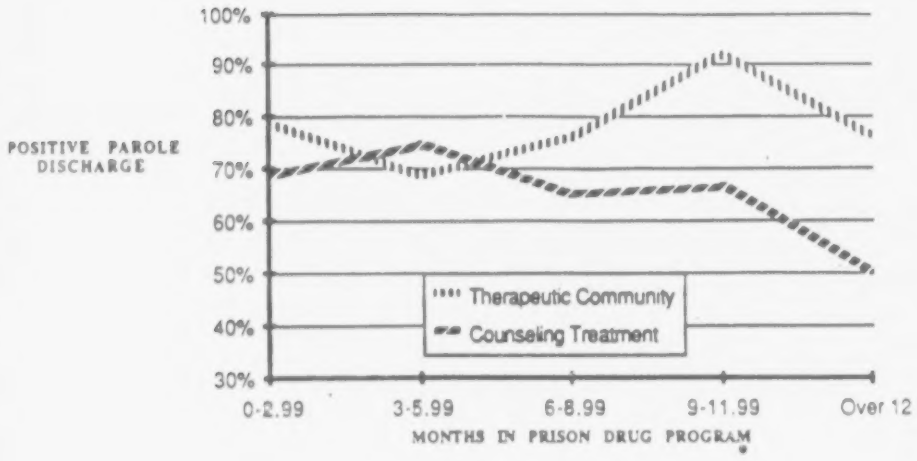


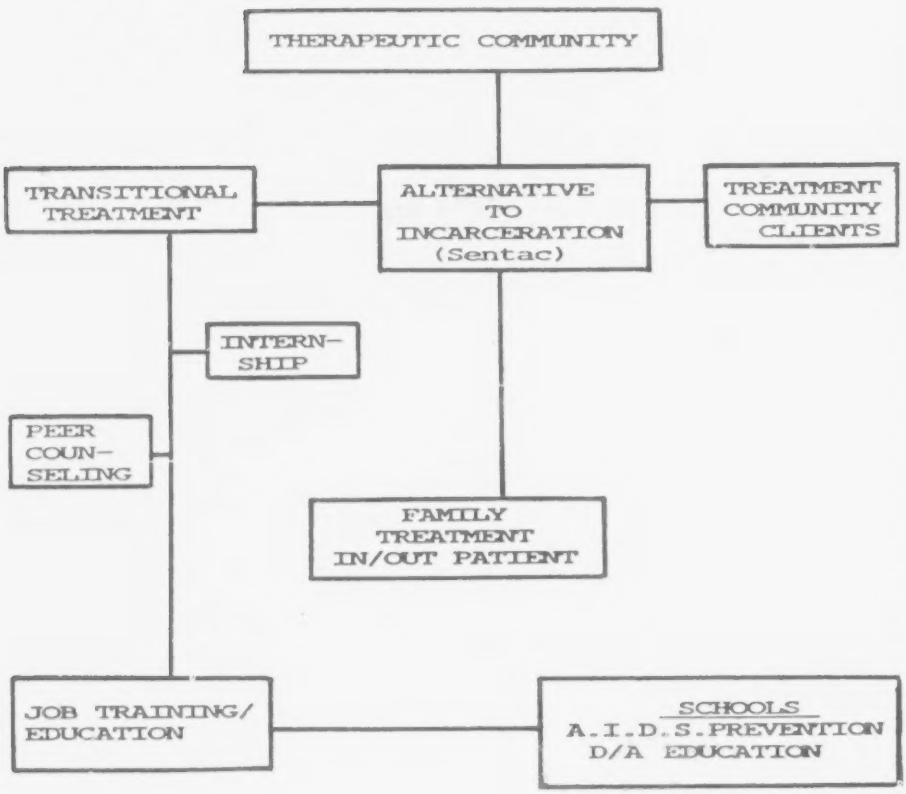
Figure 3

PAROLE OUTCOME: FEMALES

POSITIVE DISCHARGE BY TIME IN PROGRAM



THE KEY PROGRAM



THE Key
The Entrance
The Opportunity

A Therapeutic Community for Substance Abusers

Essential Elements Of The Therapeutic Community

The program is a segregated treatment unit within the prison that provides both psychological and physical safety. There are "cardinal" rules which will result in a resident being immediately discharged; drug possession, threats of violence or violence and sexual misconduct. There are several other sets of rules that must be adhered to by all residents or "family members". Any deviations from these rules will be addressed by staff, but it is the responsibility of each client to see that all family members develop prosocial values, honesty, responsibility and accountability. The residents have a system with grades or status or ranking one above another in a series from the Coordinator, at the top, to the Service Crew, at the bottom, and every one of the residents has a job function in this hierarchy. The use of this hierarchy is critical in the restructuring of the individuals life space.

The job functions are primarily used as clinical tools, not only is the resident expected to do his best in that particular job function, but might be moved when it is felt that he/she might be too comfortable in the position. There is a possibility that the resident can be put in a position of lower status to evaluate how well he/she can deal with that dynamic. Conceptually, uncomfortability illicits change.

If a client exhibits inappropriate behavior, whether it be in a job function or in a negative interaction with staff or clients, he/she may be given a learning experience. This is a method used to make the client aware that the behavior was deemed unacceptable. For example, if a client has not performed satisfactorily in a job function, and this particular client also has difficulty interacting with others in an appropriate manner, he may be told to write a composition on his lack of responsibility, and also be required to read and talk about this matter in front of the rest of the community. We believe that this is a two-tiered approach, not only dealing with teaching the resident the protestant work ethic, but might enable him/her in the future to feel more comfortable with his/her interaction with others.

What Makes The Key Program Unique?

Our schedule includes many of the traditional aspects of most therapeutic communities i.e., morning meeting, seminars, individual counseling, encounter group sessions and resident job functions by including a variety of groups, some are confrontational (encounter), where family members confront each other about their negative behaviors and attitudes.

The Program seeks a broader approach by including in its treatment model, Branch Groups, Transactional Analysis and Psychodrama.

Branch Group: a specialized dynamic where ten or more of the same residents meet twice weekly to share feelings, thoughts and attitudes; past and present. Here, residents share on an in-depth personal level inner-most feelings, form a bond of trust, identification, and understanding with his/her peers. This is not a confrontational group, but one that develops cohesiveness among the residents and is often closed by residents hugging one another, showign care and concern.

The object of the staff is "re-parenting" so residents regain positive values and skills that will enable them to deal with life on life's terms. The interventions used are:

Transactional Analysis: an analysis of the roles one plays in interaction to others i.e., parent, adult and child, and:

Psychodrama: the reliving and exploration of an unresolved personal conflict and bringing them to a closure facilitated by members of the group.

Addicts either never had or lost the skills and values that normal society takes for granted. Emotionally, they were stagnated and they lost all sense of responsibility. During their addiction they had no scruples or principles, and their feelings were suppressed. Basically, they had no idea of how to cope other than through their narcotic abuse.

What we must understand, people with long term criminality and substance abuse have difficulty being rehabilitated but we can habilitate them. Rehabilitation seeks to help unfortunates get back to where they were before, morality, productivity etc. (back on track again).

We are dealing with a segment of societies dregs that have never been given the opportunity to learn what it is like to be parented with a healthy sense of morals, values and responsibility through that process develop prosocial values.

It is The Key's philosophy to provide that dynamic i.e., habilitate, to teach the people in treatment those value systems that were not afforded to them in earlier life. This is a true concept of a community, they are being nurtured to accept responsibility for themselves and their actions, so that they may become useful and productive members of society.

Seminar

There are seminars on various topics ranging from Communication Skills to A.I.D.S. Prevention. Also, there is community and relationship training.

In the dictionary, seminar is defined as a small class for advanced study and research. We, here at The Key Program take this to another level. With such a variety of residents who are knowledgeable in specialized skills, seminars are afforded on such topics as C.P.R., communication concepts and thresholds (a decision making process). A resident may also be assigned to give a seminar as a "learning experience"; for example, a resident may have been irresponsible to his/her job function, he/she may then be scheduled to give a seminar on responsibility, as he/she sees it. Seminars are utilized for mock speaking, where resident has an opportunity to present himself as if he were on a speaking engagement representing The Key Program. Mock parole board hearings and job interviews are simulated and a resident receives feedback on his presentation.

Audio and video tapes are a component of seminars dealing with such subjects as self-esteem, self-awareness and self-actualization.

Guests are also invited into our environment to give seminars on individual topics such as A.I.D.S., intimacy, and the understanding of self and others as they cope with the various aspects of change.

The Clinical Staff also gives idepth seminars on a wide variety of topics related to "Recovery", such as addiction, treatment, therapeutic communities and lifestyles. Time is allotted for questions and answers, and residents can express their view points on the subject material.

Seminars here at The Key are a unique and rewarding experience. They are informative and a relevant component in helping a resident become a well rounded individual.

What Special Components Does The Key Program Provide?

A.I.D.S. Training

The Key has developed a module about the prevention and spread of the deadly H.I.V. virus and A.I.D.S.. Some of our residents have received specialized training in this area from professionals, and are currently going throughout the institution presenting lectures on this formidable topic. We have plans to expand this educational process so that in the future we may reach more individuals in the high risk category.

We must reduce the contagion by treating addicts, the I.V. drug user in the main vector for spreading A.I.D.S. amonth the heterosexual population.

In Dr. James Inciardi, Ph.D. latest research under a grant supported by the National Institute of Drug Abuse in findings that will be published in Contemporary Drug Problems, which alludes to the fact that drug abuse particularly crack is bringing about the destruction of our youth.

Adolescent females are exchanging sex for crack, either by prostituting for money to purchase crack and sex for crack exchanges were almost as prodominent as the monetary exchange. Through I.V. drug use or sexual interactions their is emanate danger of both contracting and spreading A.I.D.S. The average age of the adolescent female was 15 years, and some cases the females were as young as 10 years of age. The Washington Post recently reported that D.C. is twice above the national average in infant mortality stemming from A.I.D.S. via drug abuse or indiscriminate sex.

Women's Therapeutic Community

The Key Program is embarking on developing a therapeutic community in an adjoined pod. We recognize that incarcerated women have special needs as they deal with low self-esteem, powerlessness, responsibility, guilt and self-actualization.

Education and Training

It is our contention, in order to prevent the scourge of addiction, one must educate. As a result, The Key Counseling Staff and Administration, has implemented such programs by making on site and in-house presentations to adolescents, state officials, law enforcement, judiciary and correctional staff and are providing other services to independant treatment programs in Delaware. As an adjunct, the residents in treatment since the inception of the program, have been trained in group process skills. They are facilitating as peer counselors in group therapy sessions and servicing other inmates who are not directly involved in The Key Program treatment. All the above services are provided on a probono basis.

Captain Key

The residents have also recognized the need to educate children at an early age about drug and alcohol abuse. They developed a fictional character named, "Captain Key", who represents all things good and right. This comic book has been distributed to various schools in the immediate area. The State of Delaware has also entertained the thought of using this in their system.

Recovery

As a support system, we have weekly meeting of A.A. or N.A. 12-Step Programs. It is our contention that these programs are invaluable to the recovering persons and will be most helpful as they enter society.

Research and Follow Up

At this juncture, The Key Program has no graduates, as we have only been operational since July 21, 1988. Residents complete the program in approximately 18 months. We hope our first group of about 9 residents will be moving to another housing unit outside the prison shortly.

We are in a precarious position as statistics show clients do best in a prison-based therapeutic community from 9 - 12 months. If they remain in treatment any longer they tend to regress. If we can develop rapid movement in the time sequence mentioned above, it is possible that our statistical averages will be well above the normal means for such programs.

In 1988, Dr. James Inciardi, Ph.D., ad his research staff began preliminary procedures in interviewing inmates in the Delaware Correction System, including the residents in The Key Program. There will be a follow-up from their initial phases of treatment to their eventual integration into the community. At that time, there will be continual research statistics compiled on these clients.

The Key Program will work closely with the Parole Board and will orient those officers involved with our residents on parole. Supervised random urine tests will be taken on parolees and should any test positive for mind and mood altering chemicals including alcohol, they will be expelled from the program and most likely be sent back to general population in the prison system.

A) The support that the Department of Correction can muster must be the foresight to look at continuity of treatment. As stated previously, inmates in prison-based therapeutic communities tend to regress if treatment is longer than 9 - 12 months without movement to a community based facility. Funds have not been allocated for this critical phase of treatment.

B) A segment of the inmate population needs specialized treatment.

C) Treatment models should be as atonomous as possible.

D) Training needs to be provided for the administrative and correctional staff.

E) Personnel from treatment programs need to have input in interviewing and selection of perspective correctional staff who might be assigned to the program or area.

F) Treatment personnel should be the primary evaluators for inmates entry into treatment and judgements accepted by administrative and correctional staff.

Summary

It appears that participation in a prison-based therapeutic community can lead to a reduction in the incidence of parole revications. If this is the case, then the selection of the therapeutic community as a treatment modality for substance abusers. The treatment modalities used in a therapeutic community appear to be powerful enough to get individuals to restructure their life to the point that pro-social thinking patterns dominate their perceptions of the world. The therapeutic community has been found to be the most effective treatment modality for substance abusers. If this is correct, then the prison-based therapeutic community, with continued community based treatment should help break the drug-crime connection.

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The CHAIRMAN. Mr. James, let me begin with you.

You indicated that you went through several treatment regimes during your 18-year struggle with the drug problem. And as I understand it, you said there were periods as short as several months and as long as four years that you were clean. I assume that the four-year span was since you got out of the 18-month program; is that correct?

Mr. JAMES. No, I had not counted that; I don't count this.

The CHAIRMAN. Okay. So prior to the 18-month program, you had at one point gone four years where you were clean?

Mr. JAMES. Yes.

The CHAIRMAN. It may be somewhat anecdotal, but do you recall the incident that caused you to get off the wagon—wrong terminology, but "off the wagon"—after four straight years?

Mr. JAMES. Well, I have to say that anyone—any alcoholic, or any substance abuser—who attributes the cause of a relapse to a single incident does not really have a strong understanding of the nature of his condition, or is just looking for a copout. It is really more of a confluence of events and emotional condition that lead to this, and generally it is where a person does not have alternatives. The drive may be strong, the drive may be there to pick up the substance again, but a person has to have learned alternatives and methods to do something else, and that was what was missing in my case.

The CHAIRMAN. I asked one of the Nation's leading experts—not an abuser—a very fundamental question that it might be appropriate to ask you. You are obviously an educated and very articulate man, and unfortunately, you have great experience in the area—unfortunately for you. In your view, what is it—well, let me tell you what his view was, and you tell me what you think.

I asked a very basic question. I asked what makes someone use in the first place, and what distinguishes those who use a drug once, whatever the drug is, and never use it again—and there are those people—from those who use a first time and use a second and third and fourth and fifth and end up in your circumstance. And he said that there have been some studies dealing with that, and the idea of the drug dealer in the schoolyard saying, "Come on over here, kid, I've got some pink and purple pills," is a misnomer; that the way most people begin the first time is through a close friend, someone whom they trust, basically saying, "I tried it. It feels good. I'm not hooked on it. Why not try it?" Someone who is close to you.

Secondly, he said the incidence of a second and third and fourth use of that drug are in direct proportion to how good the first time felt; that some people try a drug, snort coke, and it goes into their eye, and other people snort it and it hits the right spot, figuratively speaking, and it really is a real high. And he said the likelihood of them trying a second time relates—and he made an analogy—well, I won't make the analogy that he made—well, yes, I don't mean it in a snickering sense. He made an analogy to the first time a young man or woman has sexual relations. If it is in a very bad environment, if it is not physically pleasing the first time, and difficult, the likelihood of rushing out to attempt it again very quickly is not as likely as if the first time that occurs, it is done with a

partner of experience and a circumstance that accommodates that, and so on.

Would you respond to those two notions—a) the likely first-time use comes as a consequence of a friend, an associate, someone you trust; and secondly, the likelihood of continued, second and third-time use based on the experience the first time.

Mr. JAMES. Well, Senator, if we put those two cases on one side of equal signs, on the other side, we'd have to have more than one factor to bring those things about. But I do think that a large number of people experience their first—or, whatever introduction they may have to actual drug use, they probably do do it with the encouragement of friends, or someone that they trust.

The interesting thing about that is that very often they do it in spite of having received a great deal of information about the dangers, and they will do it in spite of that.

The CHAIRMAN. That's the reason I asked the question, and I'll get to that.

Mr. JAMES. Yes. So it isn't as though I did this without knowing better. I grew up in Harlem and was constantly admonished about the dangers of using drugs. As I said, I went through my childhood and adolescence and early adulthood avoiding it, primarily because it was something that I was afraid of; I had seen the results of it.

In terms of it being directly proportionate to the pleasurable experience, or that first pleasurable experience, I'm not so sure. That might be contributing to a myth and a fiction, because where heroin is concerned, I had tried other drugs in the past, and they were take it or leave it situations, depending on what else I had to do. Where heroin is concerned, almost always a person who tries heroin for the first time will get violently ill. It is your body telling you this is not something you want. Sometimes one does not get over the illness in time to experience the pleasure of the high. Nevertheless, a large number of people, including myself, will do it again—probably in response to that same peer pressure. And that is the way—I had to develop a tolerance for the drug, and I was willing to work at developing a tolerance for the drug in order to be accepted in various places. Eventually, I started to see how it had a tremendous blocking effect; more than it being a pleasurable thing, it had a tremendous blocking effect. If you have read anything about the opium wars or about opium addicts, it is very similar to that—but it is not immediate. You have to work at it.

The CHAIRMAN. Bruce, would you comment on that?

Mr. WALD. Sure. I believe that we agree, and we might disagree. Generally, I think people use because there is a need, and it might be something that they are not consciously aware of. I know in my particular case—and you know my history—I have 17 arrests and nine convictions, and I went through the New York City prison system in New York State, and the last time I left prison I had been sentenced to five to ten years for armed robbery—and given an opportunity, because I knew I would go back to prison, because I shot drugs after being away from drugs for four years. So as I call it, the disease does not stop even if you stop, unless you do something about yourself in terms of change.

I feel that I was an addict before I ever put a needle in my arm. And as far as peer pressure, we pick associates aliken to ourselves.

I remember as a kid my mother saying to me, "Why do you hang out with those bums?" And I could not understand what she meant. As I matured a bit, I started to see that I hung out with the losers because before I ever shot dope, I felt like a loser—I was insecure, I did not like me. And treatment in one of the first therapeutic communities on the Eastern Seaboard, at Daytop Village, for long-term treatment gave me some idea that I had some credibility as a human being.

So I think that the question is not just on per chance or that, yes, I might take drugs with my friends because of my insecurity, my needs, and also to prove something to them that I am all right, and I don't want them to put me down—that says something to me about the level of my own security about self.

The CHAIRMAN. Let me move to the next question, then—short-term, long-term treatment. The phrase is used by many of the folks with whom I have spoken to over the last gosh knows how many years—I have been doing this for about 15 years now—and that is that there is overwhelming skepticism about any short-term fix for treatment of any one who is addicted to drugs and that there is a need to—I don't know how many times I have heard the phrase, and when I first heard it, I kind of thought of it as one of those typical, copout phrases that one hears in our society that sound good but no one knows what they mean—at least I don't know what it means—and that is that "You've got to treat the total person." You can't just treat the physical part of the person's addiction. You can detox someone pretty quickly in some cases—a little longer in others—but that is only the very beginning. You have got to change their attitude.

Tell me about how your program, the KEY program within the Delaware corrections system that you run, deals with that aspect, the total person.

Mr. WALD. Surely. The first thing I'd like to note for the record is I have been in the business for close to 30 years, have worked for most of the major therapeutic communities, have been in private practice, have worked in a 12-step, treatment-oriented program that was 30-, 60-, 90-day treatment. I have been a trainer and have trained professionals in group process. So we come to Delaware with those experiences, and we are asked to start, quote, "a therapeutic community".

Given those experiences and seeing many of the people, including myself, when we graduated the program having gaping holes—yes, we dealt with some of the problems, but we did not deal with some of the stuff that was inside. So it was my contention, and because of some of my training, that we added some dynamics that we felt would deal with—we are talking about holistic treatment.

The first thing we have to look at, Senator—we are not talking about rehabilitation. We are talking about habilitation. Rehabilitation says let's get you back to where you were before. Where was I before? I was one of society's dregs that ran the streets and had nothing to give to society. So what—are you going to get me back to that?

Habilitation relates to, as I see it, reparenting. We present parental figures that teach the clients the things that they never

got—honesty, integrity, a sense of responsibility—through a specialized system that you saw.

We have very in-depth groups. Most therapeutic communities deal with some feeling groups and encounter groups, which are a confrontive thing. I think that is excellent. But we also added psychodrama, which deals with some situations in an "imaginary" way that the client never had resolved with friends or family. We also deal with transactional analysis, which gives the client, as he interacts with someone else, some basis to know what ego state is. What I mean by that is, am I acting like a little kid; am I acting like a parent toward this other guy; or am I acting like an adult, and making that kind of realistic, responsible judgment.

Along with that we have people from the outside; we have extensive training. Right now, Senator, my clients—we have 30, in fact, and are getting in 20 females—some of the original guys who started with us—we have been in business a year, as you know—are doing peer counseling for the prison system at Gander Hill. That is quite a lot to say for some guys that were in for armed robbery, long-term felons, who are working in hand with the Department of Corrections, and the Department of Corrections is saying, "We can't believe these guys."

We are going out into the community, pro bono, going to schools. I have involved other programs who are profitmaking to come and learn from us, and we are not charging them.

My problem is—getting back to your question on holistic treatment—one of the problems that we see is lack of foresight. Our program does not stop when these guys finish treatment in the prison. What do you do with them then? Send them out onto the treat when they've had a year of treatment—they need community-based treatment.

As the commissioner from New York alluded to, New York has many therapeutic communities. Senator, as you know, Delaware has none. So what we foresee is developing a KEY program outside that will handle three segments: (1) the inmate leaving; (2) as Governor Castle mentioned, the SENTAC people, alternatives to sentencing, have a treatment center for long-term people; (3) deal with the community people who have addictive problems.

And one of the things that I did not hear mentioned, that my assistant director made me aware of, is what are we doing with family systems; what are we doing with the single parent who has an addictive problem and children? We want to have family therapy in that facility. So we are going to hit as many tiers as possible, and to me, that is holistic.

Thank you.

The CHAIRMAN. Mr. James?

Mr. JAMES. I agree with just about everything that Mr. Wald said—in fact, I agree with everything that he said, that there is a need for broad-based treatment. I don't care to make any choices about what clinical modalities are applied; probably any number of combinations of modalities can make inroads into that morass of problems.

What is necessary is to provide language for the addicted person to be able to discuss what is going on inside and make them aware of behavior and emotional conditions.

In my job at the Fortune Society, I meet people very day who have been through the shock incarceration in New York State—well, not every day, but I have met people from two groups that came out of there; they were young people. I have also met people who have come through a program called—I don't know if it ASAP or ASAT—which is probably the counterpart of what you do in the KEY program. It is an institution within an institution type therapeutic community. And I find that the people coming out of shock incarceration have not necessarily expressed much understanding of addiction; they have come out with unrealistic expectations; they have been trained in teamwork. They come out with a great deal of esprit de corps and rah-rah-rah, but with very little nuts-and-bolts preparation for dealing with the realities, and there has not been enough put in place to help them make the transition. And the Fortune Society, who has been in business for 20 years to do just that, has not been able to impact on the disillusionment. A person who comes out expecting little seems to fare better than the person who comes out with greater expectations.

With regard to the people who have experience long-term treatment programs in the prisons, they come out expressing generally a good deal of understanding about the nature of addiction and willing, in many cases, to go on and seek other ongoing treatment avenues.

Short-term treatment, six months, a year, detoxification and things like that, serve to take away illness. Long-term treatment is to teach the person the drives for the need to use a substance to feel better.

In my own case, I boil it down to coming to grips with the fact that we experience peaks and valleys emotionally, and being prepared to ride out the valleys, on toward the next peak, and not take something in the valley so you can feel better.

The CHAIRMAN. One of the things that strikes me as we hear these discussions—and I really should move on, but I am fascinated by this—I met Mr. Wald's inmates, his clients. There probably were some exceptions to what I am about to say, and I say this in no way to denigrate any of the inmates—most of the inmates were as Mr. Wald described himself—and you can obviously see the change that has taken place from the time he referred to himself as "a dreg on the street"—he is clearly no dreg; he is a great contributor to our community. But these men were what the average American would look at and say, "I don't want to meet these folks when they're not in this facility." I sure would not have wanted to have met them prior to them getting into this facility.

But there is a whole group, tens of thousands of people like you, who I would have liked very much to have met prior to you getting in. No one, I suspect, ever viewed you as a "dreg of society" prior to your addiction. And there are those people who are seeking help, who are addicted, I guess mainly, originally, through cocaine now, who are people who have otherwise been viewed as successful—obviously, not successful because of their image of themselves.

So that you have a man like you, who avoided the problem through grade school and high school and went off to college, started a promising career, of all things, in the most establishment field in the world, banking, and you end up with a problem. I guess, like

you say, like alcoholics, at least for today you have beaten the problem. And you are here, one of the most articulate witnesses we have had or will have, whether or not they are testifying to their own problem or testifying to the overall concern that faces this country.

My question is this. Are the long-term treatment programs fundamentally different in what is going to work for the women and men who are from your background and experience in terms of quote-unquote "success", and the women and men who are from Mr. Wald's background and experience. We have heard about Mr. Wald's program, teaching people how to read within the system. That was not a formal program, but I saw inmates teaching other inmates how to read; teaching them basic, fundamental manners, if you will, comity in society; teaching them basic, fundamental things like how to make a bed and keep a room neat. And I imagine there are tens of thousands of people out there who know all those things, who read very well, better maybe than the three of us, who know how to keep their rooms very neat when there weren't maids available to do it—a totally different "class" of people in terms of their background, education, drive, up to the point where they became addicted.

Now, tell me, is it necessary that there be a panoply of long-term treatment programs that are designed for different people with different backgrounds to enter—or does it matter? In the program that you were in, Mr. James, were you with Mr. Wald as he described himself 25–30 years ago?

Mr. JAMES. Absolutely. And while my background up to the point of my addiction might have been different than his, the character flaw was probably very similar, because whatever promise that everyone may have thought that I held, I certainly threw it all over, and the depths that I descended to during my addiction are things that I shudder every time I think about the things that I have been through and the things that I have done.

As far as persons who are affluent professionals, people not in the street life, who sort of use drugs casually, I really don't know what to say. That probably needs to be thought out. I hate to make a running comment on that without having really through it out. But I'd like to say that before anyone can benefit from treatment, they have to acknowledge addiction; they have to acknowledge that something is out of control, and they have to acknowledge that they are acting out something that is deeper than the surface.

I might also say that in no way and at no time is the criminal justice system going to be able to deter people from using drugs. Even if the use of drugs became a capital crime punishable by death, I doubt if it would have a great deal of impact since drug abusers, particularly IV drug abusers, heroin and cocaine addicts, and also crack addicts, run the risk of dying every time they pick up the substance—you never know what you're buying when you are buying it in the street from somebody who is only in it for the money—the possibility of contracting AIDS, the degradation that one experiences during the period of addiction—if these are not deterrents, going to jail, which very often is a rescue, is not going to be a deterrent.

The CHAIRMAN. Well, that was my last question. Do you think increasing the penalties—you heard the Governor testify, saying five grams, three years automatically. Is that going to have any impact on whether or not anybody——

Mr. WALD. Can I address that, Senator?

The CHAIRMAN. Yes, absolutely, both of you.

Mr. WALD. From my experience, that doesn't do a thing. Everybody tends to get scared because the problem is multiplying; instead of dealing with the solution, we are dealing with the symptom. Lock them away; we won't see them anymore—oh, now he has a speck—let's put him away. That is dealing with society's fear. What I am saying is that, yes, some people need to go to prison, but do something while they are there, and continue the process.

One of the things that you talked about—when I went into the treatment center many years ago, most of the people in treatment—and I was the exception—were college graduates. It was primarily a white treatment center. Most were professionals. And they had more denial about their addiction, and it took a longer time to break through those barriers.

The CHAIRMAN. Okay, but my question specifically is—and this is my last question—does making the sanction for use harsher in any way, in either of your views, deter (a) the first instance of use, and (b) the person who already is using. Is it of any deterrence?

Mr. JAMES. During the time between my first exposure to drugs and today, I'd say sanctions may have tripled in terms of length of sentence in New York, and has probably escalated by a factor of ten. If that is any indication, no.

If you are talking about the casual user, will he refrain from picking it up from a punch bowl at a party? I think the question is will he refrain from going to the party; will he reorient his entire social structure—no, probably not, because these people know even now that with existing sanctions, they run terrible risks of the destruction of their careers and everything that is important to them—but they do it anyway.

I think it goes more back to what Governor Castle was talking about. This is something that is deep-seated in the community psyche. It has something to do with the erosion of family. On the individual level, it has something to do with personal self-image. It is not something that the criminal justice system can impact on as such, but once they get someone locked up, they have to view that as a window of opportunity for intervention rather than returning the person to the community in the same condition in which he left it.

The CHAIRMAN. Thank you, Mr. James.

Mr. WALD. Senator, to add one little thing, let's say maybe you can impact on possibly 2 percent of the whole group of people who use, for whatever reason. Most of the people who use who are professional use the rationale that they don't have a problem; that society looks at it, because of the fact that the people in the judiciary need money, and judges, and law enforcement needs to make a big thing. They lie to themselves. How much impact? I doubt whether you'll have much.

The CHAIRMAN. Gentlemen, I want to thank you very, very much. I have several other questions I'd like to submit to you in

writing; if you would be willing to answer them, it would be much appreciated. I thank you both very much. You have both been very good witnesses.

Our next panel includes Dr. Addis Dolente, Program Manager, Substance Abuse Unit, Hillsborough County, Florida Sheriff's Office. The program is one of three jail-based programs in the county that offers treatment to drug offenders.

We welcome also Mr. John Buchanan, Lieutenant of the Phoenix Police Department, Program Coordinator for Phoenix Police Department's Demand Reduction Program that is targeted at casual users. The program permits felony charges to be dropped after successful completion of a drug treatment program.

Thank you very, very much for your patience and for your willingness to participate in the first instance.

Dr. Dolente, we will begin with your testimony and then the Lieutenant, and then we will go to questions.

Again, if you could keep your statements summarized in the five-minute range, I would appreciate it.

STATEMENT OF A PANEL INCLUDING: DR. ADDIS DOLENTE, PROGRAM MANAGER, SUBSTANCE ABUSE UNIT, HILLSBOROUGH COUNTY SHERIFF'S OFFICE, HILLSBOROUGH, FL; AND LT. JOHN BUCHANAN, PROGRAM COORDINATOR, DEMAND REDUCTION PROGRAM, PHOENIX POLICE DEPARTMENT, PHOENIX, AZ

STATEMENT OF DR. DOLENTE

Dr. DOLENTE. I thank you for being given this opportunity to testify.

Our program, the Hillsborough County Sheriff's Office Substance Abuse Treatment Program, was one of three developed out of a grant by the Bureau of Justice Assistance called "Drug Treatment in a Jail Setting: National Demonstration Program". We were one of three sites selected across the country, and the idea was for each of the three selected sites to develop a model jail drug treatment program that other jails could come and see and maybe copy if they had a similar population and similar needs.

The program is administered by the American Jail Association and is targeted to the pre-trial offender. In Hillsborough County, we have mostly pre-trial, short-term offenders who come through the jail, and they are out in six to eight weeks. So we feel that that is a really critical time to intervene with these offenders, and that time right after arrest and right at the beginning of incarceration can represent a crisis time where a person may be a little bit more ripe for intervention when they are facing the cold, hard wall of the consequences of their behavior there.

On the structure of the program, we had gotten the assistance of the Florida Mental Health Institute, part of the University of South Florida, and we designed an intensive four-week treatment program followed by linkage to community resources for the long-term, so it is not really a short-term; it is just the front part of what is a long-term program with the community picking up the ball. It involves a system of teamwork between the jail treatment staff, the judges in the community, the probation officers and the community treatment agencies.

When an inmate gets into the program, the judges are made aware of their participation, and what their aftercare treatment needs are, in the hopes that they will go ahead and order the aftercare if probation is appropriate; if they are thinking of returning that individual to the community, then the probation officer is made aware of what is going on with that person, what his aftercare needs are, and they provide more intensive supervision to make sure that they are getting the treatment, getting the frequent and random urinalysis and supervising them through what is a year or more of treatment in the community.

We get people into the program; possible candidates are identified at the time of booking or they can refer themselves into the program. In a lot of cases, judges are referring people into the program, saying a person has to go through our program, followed by probation in the community.

We place inmates who are in treatment into a 48-bed treatment pod, which is sort of like a dormitory-type setting, and we have a treatment milieu created with an emphasis on recovery, cooperation, interdependence.

Treatment is conducted in small groups of 8 to 12; we have five treatment counselors. They get treatment two hours a day, five days a week, with an hour or more of homework, so to speak, which they take back into their pod with them.

Since we began in June of 1988, we have had about 700 people go through the program. Again, the program was designed to target the pre-trial offender. This is sort of the revolving door type offender that we see who goes through the jail over and over, time and time again, and without treatment we see him right back again.

So once they get into the program, what we do is we put them through an extensive evaluation to determine what their treatment needs are. Then, once they get into treatment, the first stage is a motivational group, which lasts about a week, focusing on their commitment to treatment and the impact that substance abuse has had on their lives. Then they get into the relapse prevention group, which is the core of our program.

What is relapse prevention, and what makes it different from other treatment approaches? The relapse prevention model was developed in the early Seventies and has been applied successfully in a variety of addictive disorders like heroin and alcohol abuse, smoking, gambling, overeating, and deviant sexual offenses. And the Hillsborough County Sheriff's Office Program represents the first comprehensive relapse prevention program which specifically targets the drug-involved jail inmate.

Now, according to the relapse prevention model, there are a lot of warning signs that occur before relapse to drug use for a person who is trying to maintain abstinence. This could include negative attitudes and emotions, a buildup of stress that they do not know how to handle, frustration with life's difficulties, or involvement in certain high-risk situations which we identify at the beginning for the person.

According to this mode, if a person can recognize his individual warning signs long before they actually get to the party with the friends, with the drugs right in front of him, he can take steps to detour himself from ending up in those situations by using alterna-

tive coping strategies which we teach them in the jail and which they rehearse before they ever get out there.

Researchers working with drug abusers have identified several categories of high-risk situations which present a risk, such as the powerful urges and cravings especially that accompany people who are trying to get off of cocaine; pressures from others to use, their friends; negative emotional states like depression, anger, boredom, frustration, that kind of thing, or even positive emotional states like feeling good, wanting to celebrate being out with the gang, wanting to have fun; stress produced by conflicts with other people.

As Mr. James was saying, a lot of times, drug-involved individuals do not have any other strategies for dealing with those types of situations. They do not know any other way other than using drugs to handle those types of lows or valleys that they find themselves in. So for each individual in treatment, we first pinpoint high-risk situations that have prompted drug use in the past, on a very individual basis, and then we teach them the specific and practical skills they can use as alternative coping strategies. This is the real nuts and bolts of how do you do it.

We are using strategies that other addicts have found to work in the past. What kinds of skills? We teach them social refusal skills, assertiveness training. It is one thing to say to someone, go out there and don't use, but what do you say to people when they come up to you—exactly what do you say? A lot of these folks don't have real good social skills, and they don't know how to extricate themselves from these types of situations.

How do you handle these cravings that come up? A lot of people don't know what to do. Anger management—if some people use in response that they get up-tight and angry, what are some other ways to deal with that?

And then we also help them develop a blueprint that they are going to use for long-term recovery, including the long-term strategies for changing their lifestyle, building a new social network. I mean, we say to these folks, don't hang around your old friends—well, what are they supposed to do when all the people they knew were drug abusers, and the only activities that they knew to involve themselves in were activities where drugs were present. They are going to need a blueprint or concrete strategies on how to structure their lives differently, how to make new friends, how to engage in leisure activities that do not have anything to do with drugs. A lot of folks simply do not know how to do that since they have been involved in drugs our treatment population average of at least five years. And also we get them hooked up with the existing community network of educational and vocational services.

We also teach them the skills to use in case of a relapse, using the analogy of a fire drill—it is an event which we hope doesn't happen, but if it happens, you darn well better have a strategy already mapped out in advance on how you are going to deal with it. And like a fire drill, it is not giving permission to set a fire, but what to do in the event that a relapse should occur.

Then with the follow-up, we track them once they are released into the community for six months, looking at how they are doing, whether or not they return to drug use, whether or not they commit more crimes, did they get a job, those sorts of things.

One more thing. During the course of the program we have developed a treatment curriculum, and one of the objectives of the project is to share this curriculum—this is it right here—and start-up information with other jails in seminars sponsored by the American Jail Association. We have already had one jail decide to use our curriculum and I think possibly two more. I can't say it all in this short of time, but I extend an invitation to you or any of your staff to come down and see our program first-hand in Tampa.

Thank you.

The CHAIRMAN. Thank you. I have a number of questions, but let's hear first from Mr. Buchanan.

[Prepared statement of Dr. Dolente follows:]

HILLSBOROUGH COUNTY SHERIFF'S OFFICE

DETENTION DEPARTMENT

SUBSTANCE ABUSE TREATMENT PROGRAM

WALTER C. HEINRICH, SHERIFF

TAMPA, FLORIDA

Testimony prepared for the

Senate Judiciary Committee Hearing Entitled:

"Incarceration and Alternative Sanctions for Drug Offenders"

Tuesday, July 25, 1989

Submitted by:

Addis Dolente, Psy.D.
Program Manager
Substance Abuse Unit

THE HILLSBOROUGH COUNTY SHERIFF'S OFFICE

SUBSTANCE ABUSE TREATMENT PROGRAM

The Drug Use Forecasting studies sponsored by the National Institute of Justice have found that in many urban areas, approximately 70% or more of arrestees coming into the jails are drug-involved, with the majority dependent on cocaine. We know that when these people leave jail without receiving drug treatment, they often go back into the community to continue a pattern of crime.

In response to this crisis, the Bureau of Justice Assistance has sponsored the development of three model jail drug treatment programs, one of which is the Hillsborough County Sheriff's Office Substance Abuse Treatment Program. The American Jail Association administers this grant program. The Bureau of Justice Assistance designed this project to develop models for other jails to use in implementing drug treatment in their facilities.

We feel that the pre-trial period of incarceration is a critical time to intervene with drug-involved offenders, and if an entrance to treatment can be provided at the jail level, meaningful intervention can be a springboard to the long-term treatment necessary for drug abusers with severe and chronic problems. We have designed our program so that jail inmates can learn several basic skills that can be taken with them when they leave jail, to serve as building blocks for further treatment which they will receive in the community. We help each inmate develop their own "blueprint" for recovery and specific day-to-day coping strategies for remaining drug-free. This program was developed with the assistance of the Florida Mental Health Institute, part of the University of South Florida.

PROGRAM STRUCTURE

The Hillsborough County Sheriff's Office model of jail drug treatment consists of an intensive 4-week treatment program, followed by linkage to community agencies for long-term aftercare. The Substance Abuse Unit staff consists of five counselors. Four are assigned to work with male inmates, and one is assigned to work with female inmates. Treatment is conducted in small groups of 8 to 12 inmates, for 2 hours per day, 5 days per week. Approximately one hour of "homework" is assigned each day. Treatment of inmates began in June of 1988. Approximately 700 inmates have undergone treatment. This model was designed for a pre-trial population whose stay in county jail averages 6 to 8 weeks.

Possible candidates for treatment are identified at the time of booking through use of a special questionnaire. Inmates can also be referred by other jail staff, the courts, probation, or can self-refer. Candidates' jail records are screened by jail treatment staff and again by Classification staff to determine each inmate's appropriateness for treatment. Program staff screen out those with violent charges such as murder or sexual assault.

When Classification approval is given, program participants are placed in a 48-bed treatment pod in a direct supervision setting. In the direct supervision model, an officer is placed in the housing area with the inmates, and interacts continuously with them, rather than being separated by bars and glass. This setting allows for a maximum amount of interaction among group members in a dormitory-style housing area. A treatment milieu has been created with an emphasis on recovery, cooperation and interdependence.

Once inmates are screened into the program, they undergo an extensive evaluation, the purpose of which is to determine each inmate's treatment needs. The evaluation focuses on substance abuse history, as well as other emotional and life problems.

Inmates begin treatment by attending a motivational group to help them focus on their commitment to treatment and to explore the impact that substance abuse has had on their lives. This group lasts approximately one week, after which participants enter the relapse prevention group, which is the core of our program.

RELAPSE PREVENTION TREATMENT

The Hillsborough County Sheriff's Office program represents the first attempt to develop a comprehensive relapse prevention program that specifically targets jail inmates. The Relapse Prevention model was developed in the early 1970's and has been applied successfully in the treatment of a variety of addictive disorders such as heroin and alcohol abuse, smoking, gambling, overeating and deviant sexual behavior. According to the Relapse Prevention model, there are many warning signs that occur before a relapse to drug use. These may include negative attitudes and emotions, buildup of stress, and involvement in high-risk situations (situations which in the past have led directly to drug use). If a person can be taught to recognize these warning signs, he/she can often take steps to avoid relapse. This can be done through use of alternative coping strategies which inmates have learned and rehearsed in treatment.

There are a number of situations which have been identified as presenting a high risk for relapse for individuals recovering from drug addiction. These include:

* Experiencing powerful urges and cravings for drugs
* Pressures from others to use drugs
* Negative emotions such as depression, anger, or boredom
* Positive emotions, such as feeling good about how things are going, wanting to celebrate, or simply wanting to have a good time with friends
* Stress produced by conflicts with others and dealing with day-to-day frustrations

Most drug-involved individuals have no strategies for dealing with these situations other than using drugs. For each individual in treatment, we pinpoint high risk situations that have prompted drug relapse in the past, and teach them specific and practical skills which they can use as alternative coping strategies. These skills include strategies for dealing with urges and cravings, social refusal skills and assertiveness techniques, strategies for anger control, and ways of handling frustrations and conflicts with others. In addition, we help them develop long-term strategies for changing their lifestyle, such as building a new social network, developing drug-free leisure activities, and using the existing community network of drug treatment and vocational/educational services. Since we know that successful recovery often includes several relapses before long-term abstinence can be achieved, we teach inmates how to prepare in advance for the steps that they will need to take in the event of a relapse. It's important that they do not interpret a relapse as a total failure, but as a sign that they need to stop and evaluate the warning signs which led up to the relapse, and to strengthen their coping skills.

COURT AND COMMUNITY LINKAGES

Once an inmate has entered treatment, notice of his/her participation and a recommended aftercare treatment plan is sent to the judge, public defender, state attorney and probation officer, so that aftercare needs can be considered if an inmate returns to the community. Often the judge will order aftercare as a condition of probation. Once the inmates are released from jail, they are linked with community treatment agencies that will provide the recommended aftercare treatment (inpatient or outpatient therapy, Narcotics Anonymous Groups, and frequent, random urinalysis). The jail treatment staff, judges, probation officers and community treatment agencies work together as a team to ensure continuity of supervised care.

PROGRAM EVALUATION AND FOLLOW-UP

With the help of the Florida Mental Health Institute at the University of South Florida, the progress of all program participants will be tracked during treatment, and for six months following their release from jail. Evaluation data will include information regarding participation in community drug treatment, probation violations, re-arrests, and relapse to drug use.

There are several ways that we are measuring inmate progress during treatment. One is to look at inmates' abilities to develop specific strategies for dealing with high-risk situations. Our results indicate that there are significant improvements over the course of treatment in abilities to handle group situations in which drugs are present, one-on-one situations in which pressures are exerted to use drugs, and situations in which individuals are tempted to test personal control over drug use. Other results indicate that inmates completing the treatment program: (1) have a better understanding of relapse prevention concepts, (2) are better able to apply these concepts, (3) are better able to identify their own individual warning signs for relapse, (4) have more coping skills for dealing with high risk situations.

Post-release evaluation data is obtained from probation officers, telephone interviews with participants, and examination of NCIC/FCIC databases, to determine whether a person has been re-arrested. Early results from the first small group of participants indicate that most have been able to successfully use relapse prevention skills to remain drug-free. In addition, we will be examining data from a comparison group which has similar characteristics to our treatment group, but which did not receive treatment. This will determine whether the gains made by our treatment population were due to the treatment they received, rather than chance.

FUTURE EVALUATION AND SHARING OF INFORMATION

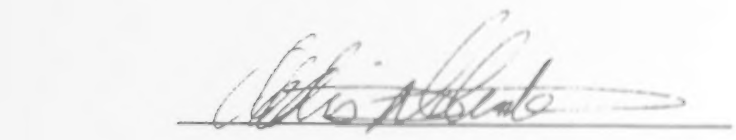
The Florida Mental Health Institute will continue to track participants completing the program for the next several years to evaluate the long-term impact of the program. The preliminary results are very positive. We recognize that most of the current data reflect progress in treatment, and that some of the important data still to be gathered will address the participants' ability to achieve long-term abstinence and long-term adjustment to the community.

During the course of the program we have developed a comprehensive treatment curriculum which has been used in several other jail drug treatment programs. One of the objectives of this program has been to share this treatment curriculum and information on program implementation in seminars sponsored by the American Jail Association. This program will also be spotlighted in an upcoming National Drug Conference to be held in November of 1989 in Tampa, Florida, sponsored by the American Jail Association, the Hillsborough County Sheriff's Office, and the Florida Mental Health Institute.

I would like to extend the invitation to all members of this committee to visit the Hillsborough County Sheriff's Office and see our program first-hand.

Thank you for the opportunity to testify before this committee.

Submitted by:



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Walter C. Heinrich, Sheriff

HILLSBOROUGH COUNTY
TAMPA, FLORIDA 33601

July 28,1989

The Honorable Joseph R. Biden
Chairman, Senate Judiciary Committee
Dirksen Building, Room 224
Washington, DC 20510-6275

Dear Senator Biden:

I would like to thank you for inviting me to testify before the Senate Judiciary Committee. If you or any other members of the committee would like more information about the Hillsborough County Sheriff's Office Substance Abuse Treatment Program, I will be more than happy to help in any way I can.

Here are the figures on the operating costs of our program, as you requested.

The Hillsborough County Sheriff's Office was awarded a grant in late 1987 by the Bureau of Justice Assistance in the amount of $300,000.00 for eighteen months. This grant is administered by the American Jail Association. The purpose of the grant entitled, "Drug Treatment in the Jail Setting : National Demonstration Program," was to create a model jail drug treatment program and to assist other jails in developing similar programs in their facilities.

The grant funds were budgeted as follows:

CONTRACTUAL SERVICES $ 50,176.00

The Hillsborough County Sheriff's Office contracted with the Florida Mental Health Institute(F.M.H.I.) part of the University of South Florida, to provide assistance with the program design, implementation strategy, selection of staff, staff training in relapse prevention techniques and substance abuse treatment, technical assistance and consultation, program evaluation and research. The Florida Mental Health Institute will be conducting our long-term tracking of program participants following their release from jail.

PERSONNEL AND BENEFITS $216,831.00

Personnel include five treatment counselors (with Bachelors degrees), one clerk typist II, and one program manager (a licensed clinical psychologist). Staff were hired in April of 1988.

EQUIPMENT $ 11,050.00

This includes office furniture for staff.

SUPPLIES $ 1,500.00

TRAVEL $ 5,550.00

This includes travel and registration for regional and national drug treatment conferences, local travel, and expenses for program manager to present the program at the American Jail Association and American Correctional Association Conferences. Also includes program manager's travel to other jails to provide technical assistance in developing new treatment programs.

OTHER $ 14,893.00

These funds were used to purchase a personal computer to handle client records, and to contract with Florida Mental Health Institute for an additional year of program evaluation and client tracking.

After staff were hired in April of 1988, two and a half months were spent in developing the treatment curriculum, record-keeping procedures, systems for linking clients with the court, probation and community treatment agencies, follow-up procedures, and staff training. Other jail programs just getting started might not need to take as much time as we did before beginning treatment, since part of this project was to develop implementation procedures and treatment curriculum to share with other jails, with the purpose of greatly reducing their program start-up time.

As a demonstration program, we budgeted a large amount of money for travel, in order to be able to share program information with other audiences. This expense, as well as the funds budgeted for contractual services would probably not be necessary for other jails starting similar programs.

The American Jail Association is currently working with a production company in preparing a documentary on the drug crisis in the criminal justice system. The Hillsborough County Sheriff's Office Substance Abuse Treatment Program, along with the two other model jail drug treatment programs funded by the Bureau of Justice Assistance, will be featured in this documentary, which will hopefully be aired on PBS.

I would like to extend an invitation to you and the other members of the Senate Judiciary Committee to visit the Hillsborough County Sheriff's Office and see our program first-hand.

Sincerely,

Walter C. Heinrich

Addis Dolente, Psy.D.
Program Manager
Substance Abuse Treatment Program

AD/lm

P.O. BOX 3371
PHONE (813) 247-6411

Walter C. Heinrich, Sheriff

HILLSBOROUGH COUNTY
TAMPA, FLORIDA 33601

August 14, 1989

The Honorable Joseph R. Biden
Chairman, Senate Judiciary Committee
Dirksen Building, Room 224
Washington, DC 20510-6275

Dear Senator Biden:

I received your letter asking for the total cost of the Hillsborough County Sheriff's Office Substance Abuse Treatment Program, the cost per participant, and replication costs. I have already mailed you information on our total program costs, but would like to provide you with the rest of the information you requested.

COST PER PARTICIPANT: approximately $280.00

This figure is derived from dividing the number of clients treated per year (720) into the program operating costs for one year. In computing operating costs, I included salaries plus benefits (Fica, Insurance, and Retirement) for five bachelor-level counselors, one clerk typist II and one doctoral-level program manager, as well as supplies and incidentals. Personnel costs now run approximately $200,000.00 per year. Supplies run approximately $1,000.00 per year. I did not include the overhead costs for incarceration, since our clients would be in jail regardless of whether or not they were receiving treatment.

The cost per participant includes approximately seven hours of interviews and assessment, followed by four weeks or more of daily group treatment (Relapse Prevention Level One). This comprises the "core" of our treatment program. Once Level One is completed, many participants continue in Relapse Prevention Level Two for several more weeks, until they are released from jail.

Replication costs might include:

Personnel	$200,000.00
Supplies (including assessment instruments)	$ 1,000.00 per year
Personal Computer System (to manage client data)	$ 4,500.00

If facility does not already have office furniture for staff, this cost would be added to replication costs:

Office Furniture and Equipment (Desks, Chairs, File Cabinets, Bookcases, Typewriter)	$ 5,000.00
	$211,000.00

Thank you for your interest in the Hillsborough County Sheriff's Office Substance Abuse Treatment Program. Please feel free to contact me if you would like any more information.

Sincerely,

Addis Dolente, Psy.D.
Program Manager
Substance Abuse Treatment Program

AD/lm

STATEMENT OF MR. BUCHANAN

Mr. BUCHANAN. Thank you, Mr. Chairman.

On behalf of the Phoenix Police Department and the Maricopa County Demand Reduction Program, we appreciate the opportunity to appear here today.

The Maricopa County Demand Reduction Program is a new and, we think, different approach by law enforcement to the drug problem at the local level. We recognize that traditional types of enforcement that are familiar to all of us, I am sure, have not had the desired impact on the availability of drugs in any of our cities, and although we think it is imperative that we maintain those kinds of enforcement strategies, undercover operations, or search warrants or whatever, something more is needed.

A major component of America's drug problem that has only recently, we think, received much attention, especially from the criminal justice system, is the demand for illegal drugs. The users have never before, especially what has been termed here, although it is a term that may have some uncertainty attached to it, casual users, have never really been the focus of serious attention. Our Demand Reduction Program targets the user, many of whom are otherwise law-abiding folks with jobs and families, for arrest and treatment. I think it is important that we have hooked those two things together.

But we are also targeting society's attitudes. In the end, we think that attitudes are the real problem. Our program involves every law enforcement agency in the county. We have consolidated resources, and we are focusing on three main areas, areas that we have heard discussed here today—enforcement—major case investigation, as I said earlier, remains a priority, but the user accountability portion of enforcement has been increased. We have developed some task force operations in the county, and adding the arrests made there to the arrests made by uniformed officers during their routine activities creates the pool, if you will, of people who will be eligible for treatment.

Eligible first offenders can take advantage of a pre-complaint diversion program. They have to pay for this treatment program themselves unless they are indigent, in which case the fees are waived, and included in the cost is a reimbursement to the jail, for instance, for the time, short though it may be, that they spend in jail after they are booked.

Costs range from several hundred dollars to over $2,000, and the time they spend in treatment may be a month or two up to over a year, depending on the seriousness of their problem. If they refuse this option, or they are not eligible for it, felony charges are filed against them by the county attorney.

A couple of important things here—no taxpayer funds are used for this treatment program, and ideally, we are trying to get hold of people before their use of drugs becomes more serious. If they complete the program successfully, no charges are filed against them. And something else that we are excited about is that there has been no court or corrections involvement in their particular case in this instance.

The third focus in addition to enforcement and treatment is education. The drug abuse resistance education program in the schools is being expanded. We have some workplace initiatives that are under way.

And thirdly, and something that has received a lot of attention, and we have an example here, is a media campaign that is only a couple of weeks old. It is the result of a public/private partnership in which a great deal of time and talent was donated, by the way, from some local ad agencies in the Phoenix area to create and produce the posters that you see here in front of you, also some TV commercials, bumper stickers, and you name it. We want to saturate the community with the message that drug abuse in Maricopa County is not going to be tolerated; we are serious about it.

Our goal, of course, using these kinds of tools and other things, is to change attitudes. That is not the usual message of law enforcement, I supposed, but we recognize that we cannot arrest everybody. We don't want to arrest everybody. We believe the answer lies in making illegal drug use unacceptable in our society, and if necessary backing that up with the threat that you see on these posters here. By the way, the "Do Drugs/Do Time" theme, if you will, "time" can have a couple of different definitions. I suppose on first looking at that, you assume that it means "time" in jail, and while there is some time spent in jail for these folks, the primary meaning of "time" is time in a treatment program, time that a person has to pay for himself.

Our program is only four months old, and as I said, the media part of it is only a couple of weeks, so it is really too early to tell what kind of impact we are having. We do want to know if it works, so in cooperation with Arizona State University, we have put together an evaluation grant proposal for the National Institute of Justice, and we are hopeful that that will be funded.

We are committed to this program in Maricopa County. As I said, every law enforcement agency in the county is involved, and we are optimistic about its potential.

Thank you.

The CHAIRMAN. Thank you very much.

[Prepared statement of Mr. Buchanan follows:]

DO DRUGS. DO TIME.

WRITTEN TESTIMONY

REGARDING THE MARICOPA COUNTY, ARIZONA DEMAND REDUCTION PROGRAM

SUBMITTED ON JULY 25, 1989

TO THE COMMITTEE ON THE JUDICIARY OF THE UNITED STATES

SENATE, JOSEPH R. BIDEN, JR., CHAIRMAN

PREPARED BY LT. JOHN L. BUCHANAN, PHOENIX POLICE DEPARTMENT

POLICE DEPARTMENTS

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AGENCIES

AZ Dept. of Liquor Licenses and Control
AZ Dept. of Public Safety
Drug Enforcement Administration
Federal Bureau of Investigation
Maricopa Co. Attorney's Office
Maricopa Co. Sheriff's Office
U.S. Attorney's Office

MARICOPA COUNTY, ARIZONA DEMAND REDUCTION PROGRAM

Mr. Chairman, Members of the Committee:

The Maricopa County, Arizona, Demand Reduction Program represents a new and different approach to the drug problem at the local level. Every law enforcement agency in Maricopa County is committed to this project that focuses on 1) Narcotics enforcement - dealer and user accountability, 2) Treatment - pre-complaint diversion for first time offenders and 3) Education - the D.A.R.E. (Drug Abuse Resistance Education) program, work place initiatives and an aggressive media campaign.

The incentive for this comprehensive approach has been building for some time. In spite of long term efforts on the part of law enforcement at all levels, the epidemic of drug use in America continues unabated. Most efforts directed toward the drug problem have concentrated on the supply. Production, processing and trafficking in foreign countries and within our own borders have been targeted. Enforcement efforts extend from distant countries to the street corners of a thousand American cities. Narcotics officers and agents conduct lengthy, complex and dangerous operations on a daily basis. Many arrests are made and large quantities of illegal narcotics are seized. And yet the drugs keep coming.

Rarely does a discernable change occur in the drug market after a major case is concluded. More often, traffickers and dealers removed from the marketplace by law enforcement are simply replaced by others eager for money and power. Meanwhile the violence associated with the booming narcotics trade escalates.

America's demand for illegal drugs supports a billion dollar industry. America's demand for illegal drugs - the one essential element that drives the entire illegal narcotics production, trafficking and marketing business. Americans who buy drugs for their own use are the last link, but the key link, in the supply chain. Though some are truly addicted, many are not. They may smoke marijuana or use cocaine on the weekends or in the evenings. Many have jobs and families and have never been arrested. These people have been labeled "casual drug users." They are responsible for a large portion of the American demand for illegal drugs.

Reduce demand and basic economics tells us that the supply will decline. Some efforts to address the demand for drugs, primarily in education and prevention, have been undertaken. But they are only now gaining momentum. In the past, enforcement and prosecution resources have not focused on the drug user. Sanctions for drug use have declined as efforts concentrated on the dealer and supplier. Crowded court dockets and jails complicate the problem even further.

This situation provided the backdrop for a series of meetings held in Maricopa County throughout 1988. The Phoenix Police Department and the Phoenix office of the Drug Enforcement Administration arranged for all law enforcement agency heads, including other federal authorities, the County Attorney, and the Sheriff to attend. Phoenix Police Chief Ruben Ortega was convinced that the supply of illegal drugs was too great too overcome, that users must be held accountable for their actions and that a regional program had the best chance for success. After it was determined that there was sufficient interest across Maricopa County, planning began.

The goal was implementation of new strategies to address the demand for illegal drugs and combine those with existing efforts into a comprehensive plan. Of course, this had to be accomplished in a way that would not overburden already strained criminal justice resources.

An Executive Committee made up of the chief executives of all participating agencies was created and the following principles for the new project were agreed to:

1. Constitutional Soundness - suspects must be afforded full protection under the constitution.
2. Popular and Institutional Support - the program must be supported by the community.
3. Flexibility - the unique needs of participating agencies and the communities they serve must be addressed.
4. Effectiveness Tempered by Fairness - the program should provide the opportunity for drug users to change their behavior while maintaining their right to function effectively in society.

A smaller group of agency heads was designated as the Program Coordinating Committee responsible for making policy. Based on the priorities established, the formal structure of the Demand Reduction Program was designed.

Advisory subcommittees made recommendations regarding legal issues, enforcement coordination, and media relations. On March 7, 1989, the Maricopa County Demand Reduction Program was announced to the public. The three major components of the project were in place.

Narcotics Enforcement - A Major Enforcement Coordinator position (a Phoenix Police Captain) was created to enhance communication about and coordination of major cases between the different agencies in the county. The new focus on demand reduction does not mean that major case investigation is less of a priority. Agencies across the county continue to conduct major investigations involving search warrants, undercover operations and wiretaps. The Major Enforcement Coordinator is charged with monitoring developments in these areas, maintaining liaison and improving coordination.

3

A User Accountability Enforcement Coordinator (a Maricopa County Sheriff's Office Major) was assigned to oversee operations directed at drug users county wide. Three local police lieutenants (from the cities of Glendale, Phoenix and Chandler) were placed in charge of task forces for the west, central and east regions of the county. Each task force is made up of officers from departments in the region and comes together on an ad hoc basis approximately once per month. Targets are chosen with input from local departments and operations generally last only a few days. The goal of each operation is to arrest drug users.

Although these task force activities tend to attract attention, the vast majority of user accountability arrests are made by uniformed officers in the normal course of their duties. Regardless of who makes the arrest, the user is booked into the Maricopa County Jail and usually released within 24 hours pending follow up on the case by the Maricopa County Attorney's Office.

Treatment - If the arrested person is deemed by the County Attorney's Office to meet the screening criteria (in general, no prior felonies or drug related offenses) he or she is notified that a diversion into treatment prior to the filing of a formal complaint is possible. The treatment program is conducted by the Treatment Assessment Screening Center (TASC - a non-profit corporation) in Phoenix under contract with the Maricopa County Attorney's Office. Post filing programs have been available in the past but this is the first time that a person could take advantage of this opportunity before the complaint is filed. The obvious benefit to the system is that the courts and corrections agencies will have no further involvement in this case if the defendant takes the diversion. If the defendant refuses the treatment option, felony charges are filed.

The individual must admit to the offense in question and pay fees to: the Sheriff's office for jail expenses incurred, the Arizona Drug Enforcement Fund and TASC for the treatment program. Costs vary from several hundred to over two thousand dollars depending on the seriousness of the person's problem and the type of substance/s they abuse. The length of the treatment program varies from a few months to over a year. If a defendant is truly indigent, fees can be waived.

The TASC treatment program consists of screening and evaluation, individual and group counselling, lectures and random urinalysis testing. If the defendant fails to complete the program successfully, the case is referred back to the prosecutor and felony charges are filed. Successful completion of the program is also reported the County Attorney and guarantees that the charges that precipitated the diversion will not be filed.

Education - A Drug Enforcement Administration Agent from the Phoenix office is the Educational Services Coordinator for the Demand Reduction Program. Prevention and educational efforts are occurring or are planned in several areas. Drug Abuse Resistance Education (DARE) is the major outreach into the schools. Efforts are underway to expand DARE.

In the work place, the major initiative thus far has involved encouraging businesses throughout the county to adopt substance abuse policies. It is estimated that non-addicted drug users are three and one-half times more likely to be periodically absent from or late to work, six times more likely to be the subject of workman's compensation claims and operate at 65% of the level of productivity of those who are drug free. In light of these estimates, increasing numbers of businesses are wiling to consider implementing a drug abuse policy.

Today in Phoenix, about 150 local business representatives are attending an all-day "Drugs in the Work Place" seminar. The conference is being sponsored by DEA and model substance abuse policies for business developed by the Demand Reduction Program will be provided to those attending.

Other educational initiatives include plans to involve local civic organizations and the creation of a speakers bureau. Qualified speakers can reach all portions of the community with information about demand reduction.

Another major educational initiative involves a multi-media campaign to inform the public that Maricopa County is serious about reducing drug use. The theme for this campaign is "DO DRUGS. DO TIME." It is important to note that "TIME" in this case may refer to time in a treatment program. Cramer/Krasselt and After Hours Consultants, both Phoenix advertising firms, generously donated their talents to create and produce television and print advertisements. Phoenix Residents Organized Against Crime Task Force (PROACT) provided funding and other assistance. The products of this public/private partnership were unveiled to the public on July 11, 1989. At a luncheon for area mayors, media managers and major advertisers the posters, bumper stickers, and television commercials were shown at the luncheon and a follow up news conference. The reception was excellent. Our goal is to saturate Maricopa County with the "DO DRUGS. DO TIME." campaign.

One of the major long term objectives of the Maricopa County Demand Reduction program is to change attitudes. Reducing social tolerance and acceptance of drug use will be difficult to accomplish. However, significant attitudinal changes about

drinking and driving have occurred in recent years. And we are encouraged that the time is right to achieve similar results with regard to drug abuse. The "DO DRUGS. DO TIME." media campaign is a key factor in our efforts to inform the public that attitudes must be altered.

The Maricopa County Demand Reduction Program has been in operation since the beginning of March, 1989. Through June, 1755 users have been arrested. 924 or 52.6% were eligible for diversion. Of the 924:

254 or 27.5%	chose diversion
51 or 5.5%	refused diversion
256 or 27.7%	have not responded to the diversion program notice
363 or 39.3%	are pending cases

Of course, it is far too early to evaluate the results of this program. We do recognize that objective evaluation is a necessary component of any endeavor. In cooperation with the demand reduction program, Professor John Hepburn of Arizona State University has prepared an evaluation grant proposal that is being forwarded to the National Institute of Justice here in Washington, D.C. The plan calls for evaluation of the outcomes of the program over a two year period. We are hopeful that funding for the evaluation will be forthcoming.

We are enthusiastic about the potential of this program. In response to numerous inquiries, we are encouraging other jurisdictions to consider demand reduction efforts of their own. The commitment of Maricopa County Attorney Richard Romley, Maricopa County Sheriff Tom Agnos and Phoenix Police Chief Ruben Ortega was essential to obtaining the cooperation of all the other law enforcement agencies in the county. There are 19 police departments and seven federal, state and county agencies involved. Such an all inclusive effort is vital if we are to be successful.

The Maricopa County Demand Reduction Program believes that as a supplement to enforcement directed against drug suppliers, the users of illegal drugs must be held accountable for the part they play in the American drug plague. First time offenders are given the opportunity and the motivation to change their behavior before they become addicted. The taxpayers are not burdened with the expense of treatment and the criminal justice system is not flooded with additional cases.

America's attitudes must change. Illegal drug use must be recognized for what it really is - a major threat to our society that will not be tolerated in our neighborhoods, schools or jobs. In Maricopa County, Arizona, we are taking this message seriously.

The CHAIRMAN. Dr. Dolente, let me begin with you. Have you identified the type of offender who will respond best to your approach?

Dr. DOLENTE. That is what we are trying to do right now. Everybody has his own theory, I guess, about whether it is the guy who is first in or the one who has been in over and over and is tired now. But when we started this program, we researched what was available in terms of solid data on this problem, and there wasn't a whole lot out there, so one of the purposes of this project——

The CHAIRMAN. Isn't it amazing?

Dr. DOLENTE. Yes. So that is what this is all about is to collect that kind of data so we can tell who this works best for, or who any kind of intervention is going to be best for.

The CHAIRMAN. How important is it that they had to be caught in the web of the criminal justice system to get a look—I mean, the fact that they have no alternative. How does that play in terms of their prospects?

Dr. DOLENTE. I think it works in a way favorably in that there are a lot of individuals who tell us, "I would have never gotten treatment if I hadn't come in here," or, "Even if I had wanted it on the street, I didn't have the money. What was available out there was more than I could afford"—or for a number of reasons. But it is a good time to catch them, and for some reason a lot of people are more ready.

I have more people sending me requests within the jail wanting to get into this program than I can possibly handle.

The CHAIRMAN. How do you respond to the generalized comments, some of which you heard in the earlier panel, that the short-term stuff really doesn't have any effect?

Dr. DOLENTE. I would say that's right. And I want to point out that this isn't really a short-term program. It is starting them out with some intensive skills, teaching them some real, practical, how-to type skills that they will continue to work on and develop, and it is made real clear to them that this is just the beginning of your treatment, and you are going to have to go for a year or more after you get out of here and return to the street.

The CHAIRMAN. Now, where do they go when you let them loose? I mean, if they don't have any money, where do they go for that treatment?

Dr. DOLENTE. Well, that's sort of the problem. In Tampa we have two treatment agencies which treat people on a sliding scale, and they'll see you for free if you don't have money. The residential beds are few and far between. There is a pretty long waiting list to get into those things, so——

The CHAIRMAN. What is the waiting time, roughly, in the Tampa area?

Dr. DOLENTE. Maybe three months to get into a residential bed. But knowing that it is just not a reality to figure that everybody that I want to get into a residential bed is, we try and work with what is out there, and——

The CHAIRMAN. I'm not being critical. I'm just trying to get a sense of where it goes.

Dr. DOLENTE. Yes, I know. And this is a situation that I think exists in a lot of cities across the United States.

The CHAIRMAN. Sure, it does. In larger cities, nine months to a year wait; in cities as small as mine, our largest city, but small relative to other large cities, three months, essentially no residential beds. There are something like 125 now statewide. It can be as few as 8 to 125, depending on whose figures you take, in the entire State, a small State, but nonetheless, it is kind of ridiculous.

What kind of support has the program received from the law enforcement community and the courts?

Dr. DOLENTE. Very good support. In fact, at the beginning, if any other jail wants to start a program similar to this, there is going to be a little leg work with the courts, letting the judges know about us and letting probation know what we are doing so we can all do that teamwork linkage. But now, the judges are so pleased with the program that they are referring people in just about almost more than we can keep up with but——

The CHAIRMAN. Is there any means by which you can, so when we ask the question of ourselves—it may not be me doing the asking, and it may not be you doing the answering—but five years from now, when we go back and take a look, will we have any basis—Mr. Buchanan indicated that in their program, they have asked the University of Arizona——

Mr. BUCHANAN. Arizona State University.

The CHAIRMAN [continuing]. Excuse me, and I realize that is a serious faux pas in Arizona——

Mr. BUCHANAN. It can't be done.

The CHAIRMAN [continuing]. That can't be done—Arizona State University—both fine universities, I might add—to help with a follow-up procedure, so five years from now you will be able to look back, and we'll have some serious data as to how the program worked in Arizona—a different program, but how that worked. Is there any such attempt to figure out how you follow people who go through the system, even though you may not be in a position to give them any reasonable alternative to longer-term care?

Dr. DOLENTE. We are working with the University of South Florida, and the Florida Mental Health Institute, and they are going to continue this project for several years and look at the folks who have gone through treatment and just address that very question, the long-term impact. In addition, we have another group of—well, they weren't participants, but some folks who did not receive treatment, who also indicated some interest, and who also indicated that they had a problem, and we are going to check those as a control group to see how people did without getting treatment to get some of this data that we need.

The CHAIRMAN. Are you finding that there is any one substance abuse that is more apparent in your community than others?

Dr. DOLENTE. Crack cocaine, in Tampa.

The CHAIRMAN. Crack cocaine. I am told crack cocaine is not physiologically addictive, but it has significant addiction as a consequence; is that correct? I know the consequences of it, but is it true that with crack cocaine—there is no withdrawal. In other words, if you take crack cocaine, and you stop the next day, there is nothing physically that happens to your body, or at least not much, as opposed to withdrawal from heroin or withdrawal from a number of other drugs.

Dr. DOLENTE. It is not quite the same. What we see is sort of an agitated depression in the weeks and couple months following, and in addition these real powerful cravings that I have spoken of. And a lot of people say that it is those cravings that made them go back, that made them relapse.

The CHAIRMAN. Mr. Buchanan, what is your rationale for targeting these people? I realize the program is very young and has not been around very long, but what does your instinct tell you where you are going to have your best shot, with what type of person?

Mr. BUCHANAN. Well, if I could use an anecdote, which I realize is hazardous sometimes, but I was on a radio talk show just the other day and a young man called and said that he had been a casual cocaine user, both he and his wife, for a period of a year or so, and then they had kind of stopped essentially on their own volition, but had recently discussed, well, maybe we ought to buy a little coke and have a good time over the weekend. And then they heard about our program. And he told me on the radio, anonymously, but nonetheless I have no reason to doubt him, that that made up his mind for him, that he had decided that this was going to help him stay away from this and just not participate anymore.

The CHAIRMAN. Because if he got nailed, he was going to do time, either time in a treatment program or time in jail.

Mr. BUCHANAN. Because he knows that we have focused attention on that kind of person, the kind of person that he is, that we feel not only is someone that we can reach and may respond to this kind of intervention, so to speak, but also constitutes a significant amount of the demand, and the demand after all is why the supply is here. If we can in some way reduce that and in a parallel fashion roll some attitudes over, similar to what has happened with DWI, I think—we have seen a change in attitudes about drinking and driving in this country in the last few years—if we see some kinds of changes about drug use, I think that the casual user will take that to heart to a certain extent—at least, that is our hope, and that is what we are targeting.

The CHAIRMAN. The answer to this question may seem obvious on the face, and I'd like you both to answer, if you could—are we in fact targeting the easiest part of the problem? I am not suggesting we shouldn't target it, but is this the easiest part of the drug problem to target.

Mr. BUCHANAN. The casual user? Well, from a strictly law enforcement point of view, I don't think so. The task force arrests we make are pretty basic stuff in law enforcement. Longer-term, more detailed, difficult investigations against traffickers, for instance, or wholesalers, are much more difficult and dangerous work. So from that point of view, I suppose the cases are easier to make.

I don't think I want to comment on the treatment part of it other than to say that before these folks get into the situation where they are less in control of their own lives and creating a burden on their families or their workplace or whatever, we want to give them an opportunity to change their lives and to straighten themselves out.

We have not been as successful as we wanted in targeting supply—and I don't think we need to shift from that. We need to continue our efforts in that regard, but I think we need to——

The CHAIRMAN. I was speaking more to the question of treatment. You both are essentially in the treatment business. You are trying to divert someone who you think may have a chance of being sucked into a permanent life of addiction or a long-term bout with addiction or, as the two gentlemen who have testified before you would argue, a lifetime addiction, that may be able to be controlled.

What you, I assume, are attempting to do is keep these people from flowing into that stream who then become the habitual criminals as well as the habitual users. And that was my question. Are we picking the easiest place in the treatment process, are we picking the clients most likely for success? I don't know the answer to that. That is a genuine question. What is your view?

Dr. DOLENTE. I think there are a couple of ways to look at it. One is it could be the hardest part to intervene because the casual user hasn't really lost that much yet. They haven't experienced some real, severe life consequences as a result of their addiction. Getting them in jail after they have been through the system a couple of times, they are beginning to. So I wouldn't call this the easiest way of intervention, but I wouldn't want to minimize its importance, either, because how many of the folks that we see now in the jail begin as these guys, the casual user.

Mr. BUCHANAN. Mr. Chairman, if I could make one comment.

The CHAIRMAN. Yes.

Mr. BUCHANAN. Many of the people we have arrested in this program so far, for instance, have jobs; some, professional people. And since to qualify, they are essentially first offenders, we have gotten some feedback about the experience of being arrested and the experience of being processed through the system just like an armed robbery suspect or a burglar or anybody else. And I realize that this may not be a popular approach or attitude right now, but I think there is some value in that experience for people. There is some value in understanding that society takes what they are doing seriously, and evidence of that by putting handcuffs on them and putting them in a wagon with a number of other people, I think that sends a message to some folks, particularly this group; that's my sense.

The CHAIRMAN. It is from an intellectual standpoint just fascinating, and from a practical standpoint really disappointing that we have so little information about the impact of societal sanctions, whether they be handcuffs or long-term incarceration or forced treatment or loss of job or loss of standing or whatever else on continued use. But it took a long time for this problem to reach crisis proportion, and I guess it is going to take us a while to bring it back into proportion, which is a way of "solving" the problem. But I am anxious to know, as you are, I am sure, in two months, in two years, in five years, the experience that will flow from what you both are doing from a different perspective.

My last question is how much does the program cost each of your counties—and if you don't know off the top of your head, if you could supply it for the record, it would be useful for us.

Dr. DOLENTE. I'll have to work that out on paper. We are a little bit different since we got started with a grant, and it was really to

develop a program, so a lot of the time and manpower that we spent was in developing something.

The CHAIRMAN. I guess what I'm trying to get to is assuming your programs have a reasonable expectation for success, and "success" being defined in terms of keeping people from first trying drugs or moving onto a second time, and/or getting people who are already users and in the criminal justice system to stop using drugs. It has been pointed out to me that almost all abusers are abusers across-the-board; if they cannot find crack, they will go to an other substance; if they cannot find a particular controlled substance, they will go to alcohol; if they cannot find alcohol—and so on.

So that the second hope is that you will have moved people who are already abusers into channels that will at least increase their prospects for controlling their addictive nature. And it is going to take time to figure out whether that works, but in the meantime there can be some signs. There will be other counties, other municipalities, other jurisdictions that are going to find your programs very intriguing. And one of the things we are going to go through here if we ever do get around to funding these programs—which is a national disgrace, in my view, that we do not—if we ever get around to that, we are going to obviously have some experimentation. The idea of going out and spending money—we have money for 245,000 treatment beds in this bill that we already passed—requires that we find which certain methods work, and which certain methods don't work. We are going to have to see what works best.

So people are going to want to look at what you have done. The Federal Government is going to want to look at what you have done. And one of the minimal things we can provide, it seems to me, is if you will, a clearinghouse for programs that we think have some promise. And part of providing that information, will be to provide for ourselves and for the other communities what the start-up costs were and what the maintenance costs are of the program. And to the extent that you could provide those for the committee, for the record, it would be much appreciated, if you are willing to do that.

It is a national disgrace and a problem—as I said, as many years as I have been trying to learn about it—and I don't offer myself to be an expert, but I do without reservation suggest that I have spent as much time as any member of the United States Congress over the last decade, trying to get a handle on this problem, from the treatment side to the eradication side in foreign countries. And all the cliches come to mind—it is a multifaceted problem that will require more than one approach; it cannot be accomplished by a single discipline, et cetera—to sum it all up, it is the single most pernicious problem that America faces. It has the ability and already has begun to impact on everything from our attitudes toward civil liberties and the Bill of Rights straight through to the confidence people have in the ability to control their own destinies.

I'll conclude by making one point. It was mentioned earlier that family structure, community values, a sense of community is important. One of the things that crack has done is it has moved into small towns, with their chambers of commerce, with their rotary

clubs, with their women's groups, still segregated in their minds as women's groups, with their churches, with their families with lower-than-average divorce rates, with their schools that have little violence or difficulty, and it has absolutely devastated those communities and in the process shaken the very foundations—that sounds dramatic—but shaken the foundations of democracy, where people think that if they had their churches and their schools and their businesses and their community organizations, and there was a sense of family and community, that that would in fact be the buffer that would keep this thing from happening to them—and it is happening to them.

So that is what I mean by the most pernicious problem, but I am an optimist. I believe there is no way in which we can stop trying, and I believe that we will in fact in the near term and longer term make significant inroads and eventually put this serpent back in the box—but it is going to take a lot of time and dedicated people like you.

Senator Thurmond and Senator Grassley have both asked me if I would insert their statements in the record, and they both may have questions for you in writing if you would be willing to respond.

[Prepared statements of Senators Thurmond and Grassley follow:]

STATEMENT BY SENATOR STROM THURMOND (R-S.C.) BEFORE THE SENATE JUDICIARY COMMITTEE, REFERENCE HEARING ON SANCTIONS FOR DRUG OFFENDERS, 228 SENATE DIRKSEN OFFICE BUILDING. TUESDAY JULY 25, 1989, 10:00 A.M.

MR. CHAIRMAN:

Today we will hear testimony on incarceration and alternative sanctions for drug offenders. The growing problem of prison overcrowding and the rising number of drug abuse related offenses have resulted in the call, by some individuals associated with the criminal justice system, for non-prison alternatives to deal with drug offenders. Although non-prison alternatives may be examined, tough punishment with imprisonment is an effective way to deal with drug related crime.

Drug abuse is on the rise in America, with crack being a major contributor to the problem. Newscasts are full of scenes of police making raids on inner city crack houses. In hearings held by the Judiciary Committee in April, we learned that crack abuse has spread into the rural parts of America as well. In addition, the drug problem facing this Nation has brought with it a level of violence we have never before seen. Desperate addicts have turned to armed robbery and other crimes to finance their habit while bloody battles over turf between drug dealers have turned our once quiet streets into war zones. Unquestionably, with drugs comes violence. As well as the violence in our streets, I am alarmed that drug related

offenders continue to abuse drugs while in prison or on supervised release. Such drug abuse leads to a vicious cycle of more and more criminal activity.

Today, we will hear testimony from representatives of various components of the criminal justice system who will discuss the efforts being waged in the fight against drug related offenders. The testimony will provide the Committee with differing proposals on how to address this problem. We will hear testimony regarding in-prison treatment programs and whether they are successful. In addition, testimony will be heard on the issue of whether the casual drug user should be punished more severely. As well, we will hear testimony regarding a new program which establishes "boot camps" with strict rules in an effort to get young people off drugs.

In closing, I know that our fight to win the war on drugs must continue with tenacity. The increase in drug abuse and the violence associated with it strengthens my commitment to increase our efforts. As a Nation, we must take every effort to fight this drug epidemic which confronts us in our cities, rural communities, and even our prisons through enactment of tough criminal penalties and education that warns everyone about the dangers of drug abuse. The testimony we will hear today should shed some light on how we can best accomplish these goals.

For these reasons, I look forward to today's testimony.

STATEMENT OF SENATOR CHARLES E. GRASSLEY
ON INCARCERATION & ALTERNATIVE SANCTIONS FOR DRUG OFFENDERS

SENATE JUDICIARY COMMITTEE
JULY 25, 1989

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MR. CHAIRMAN, I WANT TO THANK YOU FOR HOLDING THIS HEARING TODAY.

I WOULD HAVE BEEN WILLING TO PARTICIPATE IN THE PLANNING AND PREPERATION OF THIS HEARING. HOWEVER, MY JUDICIARY STAFF WAS ONLY GIVEN NOTICE OF THE EXISTENCE OF THIS HEARING ON MONDAY MORNING, JULY 24th.

IT IS A LITTLE DIFFICULT TO BE A MEANINGFUL PARTICIPANT ON ANY ISSUE -- NO LESS AN ISSUE AS IMPORTANT AS THIS ONE -- WHEN SUFFICIENT OPPORTUNITY FOR PREPERATION IS SO SHORT.

I BELIEVE THAT THERE IS LITTLE MYSTERY TO TAKING THE LONG STEPS NEEDED TO BEGIN TO SOLVE THE DRUG PROBLEM NOW RAMPANT IN AMERICA.

THE STEPS INCLUDE CERTAIN AND LONG JAIL SENTENCES FOR THE POSSESSION OF ILLEGAL DRUGS AND HARSHER SENTENCES -- INCLUDING CAPITAL PUNISHMENT -- FOR DRUG DEALERS.

UNLIKE OUR PAST EFFORTS THAT HAVE PROVED FAIRLY INADEQUATE TO THE TASK, JAPAN PUTS DRUG ADDICTS IN JAIL AND SUBJECTS THEM TO "COLD TURKEY" WITHDRAWAL. THIS HAS THE TENDANCY OF MAKING ONE RELUCTANT TO GO THROUGH A SIMILAR PROCESS A SECOND TIME.

MALAYSIA PUTS DRUG SMUGGLERS TO DEATH.

WHILE WE WILL ARGUE OVER THE EXTENT OF THE NEED FOR SUCH DRACONIAN MEASURES IN THE UNITED STATES, WE CANNOT ARGUE OVER THE RESULTS THESE MEASURES HAVE IN THE COUNTRIES THAT USE THEM.

SOME -- INCLUDING SOME OF MY FRIENDS ON THE RIGHT SIDE OF THE POLITICAL SPECTRUM -- BELIEVE THAT THE AMERICAN PEOPLE WILL NEVER STAND FOR THE IMPLEMENTATION OF SUCH SANCTIONS AND THAT WE SHOULD THEREFORE CONSIDER LEGALIZING DRUGS IN THE UNITED STATES.

I CANNOT AGREE WITH THIS SENTIMENT.

LIKE DRUG CONTROL POLICY DIRECTOR WILLIAM BENNETT, I BELIEVE THAT LEGALIZING DRUGS WOULD RESULT IN THE INCREASED CONSUMPTION OF DRUGS IN THIS COUNTRY.

LIKE DR. BENNETT, I BELIEVE THAT THERE ARE ALTERNATIVE SANCTIONS -- CONSISTENT WITH LONG-STANDING NOTIONS OF RIGHT AND WRONG -- THAT THE AMERICAN PEOPLE WILL SUPPORT.

I THINK ONE OF THOSE SANCTIONS COULD BE SENDING FIRST-TIME DRUG OFFENDERS TO "BOOT CAMPS" FOR AN EXPERIENCE -- IN DR. BENNETT'S WORDS, "SO GRUELING AND SO UNPLEASANT THAT PEOPLE DON'T WANT TO GO BACK TO IT."

THERE MAY HAVE TO BE QUITE A FEW OF THESE CAMPS AT FIRST.

AND, WE MAY UPSET THE SENSIBILITIES OF SOME BY SENDING ALL DRUG OFFENDERS FROM EVERY SOCIAL AND ECONOMIC SEGMENT OF OUR SOCIETY TO THE CAMPS. IF WE HAVE THE WILL TO ESTABLISH THEM, NO ONE SHOULD BE ABLE TO 'BUY" HIS OR HER WAY OUT OF THESE CAMPS.

DRUG USERS MUST ACCEPT RESPONSIBILITY FOR THE CONSEQUENCES OF THEIR OWN ACTIONS. THEIR CONSUMPTION OF ILLEGAL SUBSTANCES CAN NO LONGER BE TOLERATED OR CODDLED. THEIR CONSUMPTION DOES NOT CONSTITUTE A VICTIMLESS ACTIVITY.

CERTAINLY EFFECTIVE TREATMENT SHOULD BE AVAILABLE TO DRUG USERS DURING THEIR CUSTODY. HOWEVER, LAWBREAKERS -- FROM WHATEVER BACKGROUND -- SHOULD KNOW THAT, FROM NOW ON IN THE UNITED STATES, THEY ARE GOING TO LOSE THEIR LIBERTY AND FREEDOM UNTIL THEY HAVE LEARNED TO EXERCISE THAT LIBERTY AND FREEDOM AS RESPONSIBLE MEMBERS OF SOCIETY.

The CHAIRMAN. I sincerely appreciate your time and effort in coming here and your willingness to continue to do what a lot of people don't want to do today, and that is commit yourselves to public service and dealing with what is obviously a problem that no one can any longer deny.

Thank you very much. We'll ask you whether or not next year you will be willing to come back and tell us what you know about your programs that you did not know this year—and I mean that in a complimentary way. I don't mean you came unprepared, but as you have another year's experience with your programs, to tell us what it was and what it has been, if you would.

Again, thank you very, very much.

The hearing is adjourned.

[Whereupon, at 12:50 p.m., the committee was adjourned.]

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29-437 (128)